

**INSTRUCTIONS**

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08246

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>ALLEGANY</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>ALLEGANY</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>	LENGTH OF STAY (in this place) <u>29 hrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 SACRED HEART HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>637 MARYLAND AVENUE</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>EUNICE EUDORA APPLE</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept 5 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 26, 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES NORRIS</u>		14. MOTHER'S MAIDEN NAME <u>Mary Creek Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Chart</u>			
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>260 X IMMEDIATE CAUSE (A) Enterocolitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Diabetes mellitus</u>		<u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic heart disease</u>		<u>3 years</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 3</u> , 19 <u>55</u> , to <u>Sept 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 5</u> , 19 <u>55</u> , and that death occurred at <u>9:02 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Dale W. Baein</u>		DATE SIGNED <u>9-5-55</u>	
M.D. <u>62 George Cumberland Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
24. REC'D BY REGISTRAR <u>Sept. 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter L. Frantz, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis H. H. Inc.</u>		ADDRESS <u>Cumberland Md</u>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

MARYLAND

COUNTY OF \_\_\_\_\_

TOWNSHIP OF \_\_\_\_\_

CITY OF \_\_\_\_\_

BIRTH

72

IN MEDICAL CERTIFICATION

THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

BUREAU V. S.

SEP 8 1965

RECEIVED

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08247

8278

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>	
TOWN <u>Westernport</u>		LENGTH OF STAY (in this place) <u>38 yrs</u>		TOWN <u>Westernport</u>		TOWN <u>Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81 Main St</u>				STREET ADDRESS (If rural give location) <u>81 Main St</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Donald Marshall Atkins</u>				<b>4. DATE OF DEATH</b> <u>Sept 2 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>28 July 1918</u>	
9. AGE last birthday <u>38</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Westernport, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>Lloyd M. Atkins</u>			
14. MOTHER'S MAIDEN NAME <u>Grace Evers</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY NO. <u>234-26-9552</u>				17. INFORMANT & ADDRESS <u>Mrs Donald Atkins, Westernport, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Primary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 2 19 55</u> , to <u>Sept 2 19 55</u> , that I last saw the deceased alive on <u>Sept 2 19 55</u> , and that death occurred at <u>3 45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James A. [Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Westernport, Md.</u>		DATE SIGNED <u>9-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5 Sept 55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. REC'D BY REGISTRAR <u>9-5-55</u>		REGISTRAR'S SIGNATURE <u>Mr. Jon C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Westernport, Md.</u>	

# CERTIFICATE OF DEATH

1

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

SEX

CAUSE OF DEATH

PLACE OF DEATH

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CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

SEP 8 1955

RECEIVED

8239

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in the place) <u>1 mon. 3 wks</u>		CITY OR TOWN <u>CUMBERLAND</u>		CITY OR TOWN <u>CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>226 EMILY STREET</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>NANNIE L. ATKINSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9-28-55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>11-7-89</u>	
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days)		11. IF UNDER 24 HRS. (Hours) (Min.)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Barton MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES O. MILLER</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET NAUGHTON MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Nancy Newcomer Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>9-28-55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10:30</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-28-55</u> to <u>9-28-55</u> that I last saw the deceased alive on <u>9-28-55</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>J. J. Johnson</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>9-28-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-30-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Percy Cem.</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V-5 A15C-155 10M



CERTIFICATE OF DEATH

8238

THIS DEATH

AT THE RESIDENCE OF DECEASED

MARYLAND

0 - -

BUREAU V. B.

OCT 3 1955

RECEIVED

100-1038

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08249

Reg. Dist.

No. 4

## I. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland LENGTH OF STAY (in this place) 7 yrs.  
TOWN Cumberland  
HOSPITAL OR INSTITUTION OR STREET ADDRESS 128 Hanover St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
CITY (If outside corporate limits write RURAL and give nearest town) Cumberland OR TOWN Cumberland  
STREET ADDRESS (If rural, give location) 128 Hanover St.

## 3. NAME OF DECEASED:

(First) Samuel (Middle) E. (Last) Baechtel

## 4. DATE OF DEATH

(Month) Sept. (Day) 16 (Year) 1955

## 5. SEX:

male

## 6. COLOR OR RACE:

white

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

married

## 8. DATE OF BIRTH:

Dec. 20-1874

## 9. AGE last birthday:

80 yrs.

## 10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Retired Pct. Conductor Pa. R. Ry.

## 10b. KIND OF BUSINESS OR INDUSTRY:

Pa. R. Ry.

## 11. BIRTHPLACE (State or foreign country):

Maryland Washington Co U.S.A.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Unknown

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY No.:

716-09-9390

## 17. INFORMANT & ADDRESS:

(son) Harry Baechtel, Berryville, Va.

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
Immediate cause (a) Coronary occlusion

### DUE TO

Antecedent cause(s) (b) Coronary sclerosis

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

### INTERVAL BETWEEN ONSET AND DEATH

sudden

?

### II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

### 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

### 20. AUTOPSY?

Yes ☐ No ☒

### 21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

### 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

### 21c. (City or town) (County) (State)

### 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

### 21e. INJURY OCCURRED While at work ☐ Not while at work ☐

### 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐. SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Sept. 16-1955

DEPUTY MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAM. ☐

### 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

### DATE THEREOF

9/18/55

### NAME OF CEMETERY OR CREMATORY

Rose Hill Cemetery

### LOCATION (City, town, or county) (State)

Hagerstown Maryland

### DATE REC'D BY LOCAL REG.

Sept. 18, 1955

### REGISTRAR'S SIGNATURE

Walter R. Frank, M.D.

### 24. FUNERAL DIRECTOR

Louis Stein, Inc. Cumberland, Md.

### ADDRESS

Stein

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1955

BUREAU V. S.



## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8241

## CERTIFICATE OF DEATH

08250

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>MARYLAND</u>		STATE <u>W. Va</u>		COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>5 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>85x-3</u> TOWN <u>Ridgeley</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62</u> <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>Route 1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Harry Holiday Barley</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 30 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 12, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.F.W. Home</u>		11. BIRTHPLACE (State or foreign country) <u>Winchester, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Deceased Louis L. Barley</u>				14. MOTHER'S MAIDEN NAME <u>Florence Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes, 1898-1902</u>				16. SOCIAL SECURITY NO. <u>710-09-5962</u>		17. INFORMANT & ADDRESS <u>Wife- Cora L. Barley, Ridgeley W. Va.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive and arteriosclerotic changes</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>9-25</u> , 19 <u>55</u> , to <u>9-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-30</u> , 19 <u>55</u> , and that death occurred at <u>5:07 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ralph W. Ballin</u>		ADDRESS (Street, city, town, state) <u>M.D. 62 Greene St. Cumberland, Md</u>				DATE SIGNED <u>10-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Winters R. Mantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	



1

## INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8279.

## CERTIFICATE OF DEATH

08251

6

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>43 Westernport</u>		LENGTH OF STAY (in this place) <u>60 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport 43</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>314 MD Ave</u>				STREET ADDRESS (If rural give location) <u>314 MD Ave 1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>James Henry Bell</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept 15 19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>April 30, 1861</u>		<b>9. AGE last birthday</b> <u>94</u> yrs.	<b>10. IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Miner - Ret Coal Mine</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Newburg, W. Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Nimrod Bell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>SARAH Currance</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Louis Hicks 314 MD Ave Westernport</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>422.2</u>				<b>18. MEDICAL CERTIFICATION</b> <u>Chronic Myocarditis and Myocardial Degeneration</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 Years</u>	
<b>IMMEDIATE CAUSE (A)</b> <u>not specified as Rheumatic</u>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>P</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lactory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Sept 14</u>, 19<u>55</u>, to <u>Sept 15</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Sept 14</u>, 19<u>55</u>, and that death occurred at <u>3:00 A</u>.M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James B. Wilson</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Piedmont, W. Va.</u>		<b>DATE SIGNED</b> <u>Sept 16, 1955</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>9-18-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Memorial Park</u>		<b>LOCATION (City, town, or county)</b> <u>Frostburg MD</u>	
<b>24. REC'D BY REGISTRAR</b> <u>9-17-55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Margaret C. Kelly</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>E. L. Boal</u>		<b>ADDRESS</b> <u>MD Westernport</u>	

# CERTIFICATE OF DEATH

12-2-20

18851

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. MEDICAL CERTIFICATION

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

BUREAU V. S.

SEP 20 1915

RECEIVED

NOTIFICATION

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE PHYSICIAN AND HIMSELF. IT IS ALSO THE DUTY OF THE REGISTRAR TO SEE THAT IT IS FILED IN THE APPROPRIATE PLACE AND THAT IT IS AVAILABLE FOR THE PUBLIC TO VIEW. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08252

8291

# CERTIFICATE OF DEATH

Reg. Dist. No. 8

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lonaconing</u>		<u>52 yrs</u>		TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 JACOBSON ST</u>				STREET ADDRESS (If rural give location) <u>90 JACOBSON ST</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>William</u> (Middle) <u>Henry</u> (Last) <u>BERRY</u>				(Month) <u>Sept</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>20 July 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>			10b. KIND OF BUSINESS, OR INDUSTRY <u>Coal Mine</u>	11. BIRTHPLACE (State or foreign country) <u>BARTON, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Berry</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Quinn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>164-039022</u>		17. INFORMANT & ADDRESS <u>James Berry, Lonaconing, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.1 Coronary Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>				<u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/>		21e. INJURY OCCURRED		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 Sept</u> , 19 <u>55</u> , to <u>4 Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 Sept</u> , 19 <u>55</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George Ruland</u> M.D.				ADDRESS (Street, city, town, state) <u>Lonaconing, Md</u>		DATE SIGNED <u>9-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>9-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		LOCATION (City, town, or county) <u>Lonaconing, Md</u>		(State)	
24. REC'D BY REGISTRAR <u>9-7-55</u>	REGISTRAR'S SIGNATURE <u>Guadalupe M. Pool</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Pool</u>		ADDRESS <u>Westernport, Md.</u>			







8242

## CERTIFICATE OF DEATH

08253

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (In this place) 6 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS 12 FIFTH STREET			
3. NAME OF DECEASED (Type or Print) STANLEY S. BURKE				4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 4 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 25 1904	9. AGE last birthday 51 51 Yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Ridgely		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BURKE				14. MOTHER'S MAIDEN NAME MARGARET DIEHL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 214-32-3018		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
581.0 IMMEDIATE CAUSE (A) Cirrhosis of Liver						2 yrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/5/53, 19....., to 9/7/55, 19....., that I last saw the deceased alive on 9/3/55, 19....., and that death occurred at 5:15 A.M., from the causes and on the date stated above.							
SIGNATURE J. Hillcrest				ADDRESS (Street, city, town, state) Cumberland, Md.		DATE SIGNED 9/4/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-7-55		NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		LOCATION (City, town, or county) Cumberland, Md.	
24. REC'D BY REGISTRAR Sept. 7, 1955		REGISTRAR'S SIGNATURE Walter R. Teatz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CLASS

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8280

## CERTIFICATE OF DEATH

08254

9

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Allegheny</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Allegheny</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Frostburg</i>		<i>13 hrs 45 min</i>		TOWN <i>Frostburg</i>		<i>Rt 1 X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Miners Hospital</i>				STREET ADDRESS (If rural give location) <i>Miners Hospital</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Baby Boy Collette</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Sept 19 1955</i>			
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b> <i>Sept. 18 '55</i>	<b>9. AGE last birthday</b> yrs. <i>—</i>		<b>IF UNDER 1 YEAR</b> Months Days <i>13 45</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Infant</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Infant</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Frostburg, Md.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>Robert O. Collette</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Alice Carter</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mary A. Collette Rt 1 ± Frostburg, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>776x IMMEDIATE CAUSE (A)</b> <i>Premature Birth (6 hrs)</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>13 hrs 45 min</i>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>9-15</i> to <i>9-19</i>, 19<i>55</i>, that I last saw the deceased alive on <i>9-19</i>, 19<i>55</i>, and that death occurred at <i>6:15 A.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>H.C. Diehl</i>				<b>DATE SIGNED</b> <i>9/19/55</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>				<b>24. REC'D BY REGISTRAR</b>			
<b>DATE</b> <i>9-19-55</i>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>J. R. Blum</i>			

# CERTIFICATE OF DEATH

92887

BY THE

STATE OF MARYLAND

STATE OF MARYLAND

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 CAUSE OF DEATH  
 PLACE OF DEATH  
 DATE OF DEATH  
 TIME OF DEATH  
 SIGNATURE OF DECEASED  
 SIGNATURE OF WITNESS  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF MINISTER OF THE GOSPEL  
 SIGNATURE OF CLERGYMAN  
 SIGNATURE OF CHAPLAIN  
 SIGNATURE OF RABBI  
 SIGNATURE OF OTHER

BUREAU V. S.

SEP 23 1955

RECEIVED

NOTIFICATION

1. This certificate is required by law to be filed with the Registrar of the State Department of Health, Baltimore, Maryland, within a certain period of time after the death of the deceased. It is the duty of the person having charge of the funeral to see that this certificate is properly filled out and signed by the proper authorities. It is also the duty of the person having charge of the funeral to see that the body of the deceased is properly disposed of in accordance with the laws of the State of Maryland. The Registrar of the State Department of Health will issue a certificate of death to the family of the deceased, which will be used for the purpose of settling the estate of the deceased and for other purposes. The Registrar will also issue a certificate of death to the family of the deceased, which will be used for the purpose of settling the estate of the deceased and for other purposes. The Registrar will also issue a certificate of death to the family of the deceased, which will be used for the purpose of settling the estate of the deceased and for other purposes.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8281

## CERTIFICATE OF DEATH

08255

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>allegany</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>alleg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>22 Frostburg</u>		<u>14 ms.</u>		TOWN <u>Frostburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. 1, F.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Baby Girl Collette</u>				<u>Sept 19 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<u>Female</u>	<u>W</u>	<u>Infant</u>	<u>Sept. 18 '55</u>	<u>—</u>	<u>14</u>	<u>14</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>Infant</u>				<u>Infant</u>		<u>Frostburg, Ind.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<u>USA.</u>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Robert O. Collette</u>				<u>Mary Alice Collette</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
						<u>Mary A. Collette, Rt. 2, Ind.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>776X IMMEDIATE CAUSE (A)</b>				<u>Premature birth (6 mos.)</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<u>0</u>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>9-18</u>, 19<u>55</u>, to <u>9-19</u>, 19<u>55</u>, that I last saw the deceased alive on <u>9-19</u>, 19<u>55</u>, and that death occurred <u>6:45 P</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>H.C. Diehl</u>				<u>Frostburg, Ind.</u>		<u>9/19/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>				<u>Frostburg new Park</u>		<u>Frostburg, Ind.</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<u>DATE 9-19-55</u>				<u>Mrs. Nancy N. Rose</u>		<u>J. R. Wurst, Frostburg, Ind.</u>	

2195357260



# CERTIFICATE OF DEATH

RSR

See Page No.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this \_\_\_\_\_ day of \_\_\_\_\_, 1955.

DEPARTMENT OF HEALTH

NAME OF DECEASED: *John Doe*  
 SEX: *Male*  
 AGE: *45*  
 DATE OF BIRTH: *Jan 15, 1910*  
 PLACE OF BIRTH: *St. Louis, Mo.*  
 OCCUPATION: *Teacher*  
 MARITAL STATUS: *Married*  
 NAME OF SPOUSE: *Jane Doe*  
 NAME OF NEXT OF KIN: *John Doe, Jr.*  
 ADDRESS: *123 Main St., Baltimore, Md.*

CAUSE OF DEATH: *Heart Disease*  
 MANNER OF DEATH: *Natural*  
 PLACE OF DEATH: *Home*  
 TIME OF DEATH: *10:00 AM*  
 DATE OF DEATH: *Aug 10, 1955*  
 SIGNATURE OF PHYSICIAN: *Dr. J. K. Smith*  
 SIGNATURE OF CORONER: *John Doe*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

DECEASED'S SIGNATURE: *John Doe*  
 SIGNATURE OF NEXT OF KIN: *John Doe, Jr.*  
 SIGNATURE OF WITNESSES: *John Doe, Jr., Jane Doe*

BUREAU V. S.

SEP 23 1955

RECEIVED

RECEIVED SEP 23 1955



8243

08256

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Allegany	CITY (If outside corporate limits write RURAL and give nearest town)	Allegany
TOWN	Cumberland	TOWN	Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Sacred Heart Hospital	STREET ADDRESS	509 Pine Ave.
3. NAME OF DECEASED:	(First) David	(Middle) H.	(Last) Crabtree
5. SEX:	male	6. COLOR OR RACE:	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	single	8. DATE OF BIRTH:	Jan. 22-1943
9. AGE last birthday:	12 yrs.	4. DATE OF DEATH	Sept. 7 1955
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	Student	10b. KIND OF BUSINESS OR INDUSTRY:	Fort Hill H. School
11. BIRTHPLACE (State or foreign country):	Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME:	Leo Crabtree	14. MOTHER'S MAIDEN NAME:	Alberta Little
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	no	16. SOCIAL SECURITY No.:	none
17. INFORMANT & ADDRESS:	(mother) Mrs. Alberta Crabtree, Cumberland		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		4-1/2 hrs
(a) Immediate cause		
(b) Antecedent cause(s)		
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		
(a) Intracranial hemorrhage		
(b) a 38 caliber revolver bullet wound in forehead		
(c) exit, occipital region. Accidentally discharged.		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office hldg., etc.)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
Sept. 7/55 P. M.		Playing with revolver, accidentally discharged.
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE		
H. V. Deming M.D. H. V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER		
DEPUTY MEDICAL EXAMINER		
ASSISTANT MEDICAL EXAM. DATE SIGNED Sept. 8-1955		

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 10, 1955	Greenmount Cemetery	Cumberland, Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 9, 1955	Walter R. Hantz, M.D.	John J. Safes,	"

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 13 1963  
BUREAU V. 2

8244

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>				STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>99</u> <u>D.O.A. Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>525 Pine Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>ALMEDIA</u> <u>BURDINE</u> <u>DAVIS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept.</u> <u>2</u> <u>1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>July 14, 1890</u>	<b>9. AGE last birthday</b> <u>65</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Twiggstown, Md. Alleg. Co.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>James Newell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Rice</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>H.O. Davis, Cumberland, Maryland</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>arteriosclerotic Heart Disease</u>						<u>at least</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>with aortic Filariation</u>						<u>6 months</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Sept 1, 1955</u> to <u>Sept 2, 1955</u> , that I last saw the deceased alive on <u>Sept 1, 1955</u> , and that death occurred at <u>41 Greenb, Cumberland Md</u> on <u>9/4/55</u> M. from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>B. M. Schindler</u>		<b>DATE THEREOF</b> <u>Sept 4, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Davis Mem. Park</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Allegany County, Md.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REC'D BY REGISTRAR</b> <u>Sept. 4, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Walter R. Frautz, M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Hafer, Cumberland, Maryland</u>	



8245

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Allegheny</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>60 yrs.</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 325 Arch St</u>				STREET ADDRESS (If rural give location) <u>325 Arch St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rose</u>		(Middle) <u>Catherine</u>		(Last) <u>Kerlan</u>		(Month) (Day) (Year) <u>Sept 29 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug 23, 1887</u>	9. AGE last birthday <u>68</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Riggelman</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe Catherine Ebersole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Arthur Bland 325 Arch St</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident - Right</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arteriosclerosis Cardiac Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 28</u> , 19 <u>55</u> , and that death occurred at <u>5:00</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>H. Hunter</u>				ADDRESS (Street, city, town, state) <u>133 Virginia Ave, Cumberland, Md</u>			
DATE <u>9/30/55</u>				DATE SIGNED <u>9/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
24. REC'D BY REGISTRAR <u>Oct 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Grantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Form No. 10

TO BE FILLED BY THE REGISTRAR OF DEATHS

MARYLAND  
HOSPITAL  
NO. 1000

BUREAU V. 2

OCT 4 1955

RECEIVED

DEPT. OF HEALTH

THIS CERTIFICATE OF DEATH IS TO BE FILLED BY THE REGISTRAR OF DEATHS OF THE COUNTY OR CITY IN WHICH THE DECEASED RESIDES. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO SHALL SIGN AND FORWARD IT TO THE STATE DEPARTMENT OF HEALTH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO SHALL SIGN AND FORWARD IT TO THE STATE DEPARTMENT OF HEALTH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO SHALL SIGN AND FORWARD IT TO THE STATE DEPARTMENT OF HEALTH.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8246

CERTIFICATE OF DEATH

08259

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02</b> TOWN <b>Cumberland</b>		LENGTH OF STAY (in this place) <b>5/12/52</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b>		<b>02</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>91</b> <b>Allegany County Infirmary</b>		STREET ADDRESS (If rural give location) <b>439 Cumberland Street</b>				<b>1</b>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Mary</b>		(Middle) <b>H.</b>		(Last) <b>Dobbie</b>		(Month) (Day) (Year) <b>September 28, 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>11/25/1873</b>	9. AGE last birthday <b>81</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Milliner - Self-employed</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Samuel Dobbie</b>				14. MOTHER'S MAIDEN NAME <b>Alice McGee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Allegany County Infirmary Records</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <b>Chronic Myocardial Degeneration</b>				?			
ANTECEDENT CAUSE(S) DUE TO (B) <b>General arteriosclerosis</b>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Secondary Anemia</b>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic Hepatitis</b>				?			
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May 13, 1953</b> to <b>Sept. 28, 1955</b> , that I last saw the deceased alive on <b>Sept. 28, 1955</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>James B. DeLoe</b>				ADDRESS (Street, city, town, state) <b>49 Greene St.</b>			
DATE SIGNED <b>9-29-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Oct. 1st. 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
24. REC'D BY REGISTRAR <b>Sept. 30, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Fantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, MD.</b>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

82444

Reg. Dist. No.

1. Name of deceased (Print or write)

2. Date of death (Print or write)

3. Place of death (Print or write)

4. Cause of death (Print or write)

5. Nature of disease (Print or write)

6. Duration of disease (Print or write)

7. Name of attending physician (Print or write)

8. Name of informant (Print or write)

9. Age (Print or write)

10. Sex (Print or write)

11. Race (Print or write)

12. Birth date (Print or write)

13. Marital status (Print or write)

14. Occupation (Print or write)

15. Name of hospital (Print or write)

16. Name of physician (Print or write)

17. Name of informant (Print or write)

18. Name of county (Print or write)

19. Name of city (Print or write)

20. Name of street (Print or write)

21. Name of neighborhood (Print or write)

22. Name of block (Print or write)

23. Name of lot (Print or write)

24. Name of lot (Print or write)

25. Name of lot (Print or write)

26. Name of lot (Print or write)

27. Name of lot (Print or write)

28. Name of lot (Print or write)

BUREAU V. 1

OCT 3 1955

RECEIVED

Col. J. B. ...

...

George ...

SHORTS ACTION

1. Name of deceased (Print or write)  
2. Date of death (Print or write)  
3. Place of death (Print or write)  
4. Cause of death (Print or write)  
5. Nature of disease (Print or write)  
6. Duration of disease (Print or write)  
7. Name of attending physician (Print or write)  
8. Name of informant (Print or write)  
9. Age (Print or write)  
10. Sex (Print or write)  
11. Race (Print or write)  
12. Birth date (Print or write)  
13. Marital status (Print or write)  
14. Occupation (Print or write)  
15. Name of hospital (Print or write)  
16. Name of physician (Print or write)  
17. Name of informant (Print or write)  
18. Name of county (Print or write)  
19. Name of city (Print or write)  
20. Name of street (Print or write)  
21. Name of neighborhood (Print or write)  
22. Name of block (Print or write)  
23. Name of lot (Print or write)  
24. Name of lot (Print or write)  
25. Name of lot (Print or write)  
26. Name of lot (Print or write)  
27. Name of lot (Print or write)  
28. Name of lot (Print or write)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08260  
8282  
CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>43</u> TOWN <u>Westernport</u>	LENGTH OF STAY (in this place) <u>8</u> years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>43</u> TOWN <u>Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u> <u>Stoney Run Road</u>		STREET ADDRESS (If rural give location) <u>1</u> <u>Stoney Run Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Julia</u> <u>Alice</u> <u>Droll</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept 7</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 22, 1894</u>
9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Flintstone Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>David Kifer</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Shipway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Westernport, Md.</u> <u>Joseph Droll, Stoney Run Road</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>14 Days</u>	
ANTECEDENT CAUSE (B) <u>Arterio-sclerosis &amp; Hypertension</u>		<u>5 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u> <u>None</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 24, 1955</u> , to <u>Sept 7, 1955</u> , that I last saw the deceased alive on <u>Sept 7</u> , 1955, and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul B. Wilson</u>		ADDRESS <u>Redmont W. Va</u> DATE SIGNED <u>Sept 9, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Bloomington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bloomington, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-10-55</u>		REGISTRAR'S SIGNATURE <u>Mar Jean C. Kelly</u>	
24. FUNERAL DIRECTOR <u>E. S. Boal</u>		ADDRESS <u>Westernport, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 13 1955

RECEIVED

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08261

8247

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Cumberland</u>		CITY OR TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>212 Schley St</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS <u>212 Schley St.</u>		STREET ADDRESS	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Bridget Ellen Fahey</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 18 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 16, 1868</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Oakland, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Micheal Carney</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Haeghan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Micheal Fahey, Westernport, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>Con gestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerotic Cardiovascular disease</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 54</u> , 19 <u>54</u> , to <u>Sept 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>55</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. C. Hunter</u>		M. D. <u>133 Virginia Ave, Cumberland, Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>9/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 21/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) <u>Westernport, Alleg. Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Fredlock Jr.</u>		ADDRESS <u>Westernport, Md.</u>	

1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

# CERTIFICATE OF DEATH

1955

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR OF DEATHS. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR OF DEATHS.

BUREAU V. 2

SEP 21 1955

RECEIVED



8292

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08262  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 6

## 1. PLACE OF DEATH:

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

BARRON

LENGTH OF STAY (in this place)

84 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Allegany

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN

BARRON

STREET ADDRESS

(If rural, give location)

## 3. NAME OF DECEASED:

(Type or Print)

(First)

MATILDA

(Middle)

(Last)

Foutz

4. DATE

(Month)

(Day)

(Year)

OF DEATH

Sept 4

19 58

## 5. SEX:

## 6. COLOR OR RACE:

Male

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widow

## 8. DATE OF BIRTH:

14 April 1871

## 9. AGE last birthday:

84 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Domestic

## 10b. KIND OF BUSINESS OR INDUSTRY:

Own home

## 11. BIRTHPLACE (State or foreign country):

BARRON, Md

## 12. CITIZEN OF WHAT COUNTRY?

U.S.

## 13. FATHER'S NAME:

Dennis Preston

## 14. MOTHER'S MAIDEN NAME:

KATHERINE Poland

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

None

## 17. INFORMANT &amp; ADDRESS:

John Foutz, BARRON, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

Cardio-vascular-renal disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 years

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

0

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

(County)

(State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. K. Downing M.D.

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

Sept 6-1955

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

## DATE THEREOF

5-7-55

## NAME OF CEMETERY OR CREMATORY

MT. View Cemetery

## LOCATION (City, town, or county)

Moscow

(State)

Md.

## DATE REC'D BY LOCAL REG.

5-7-55

## REGISTRAR'S SIGNATURE

Mr. Jean C. Kelly

## 24. FUNERAL DIRECTOR

E. J. Boul.

## ADDRESS

WESTPORT, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

INVESTIGATION OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

REPORT MADE BY

DATE OF REPORT

REPORT MADE AT

REPORT MADE FOR

REPORT MADE BY

REPORT MADE FOR

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REPORT MADE FOR

BUREAU V. S.

SEP 8 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08263

8283

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Md.</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>22 Frostburg</u>		LENGTH OF STAY (in this place) <u>15yrs.</u>		TOWN <u>22 Frostburg</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Washington St. Ext.</u>				STREET ADDRESS <u>Washington St. Ext.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Ella Grace Gattens</u>				<b>4. DATE OF DEATH</b> (Month) <u>9</u> (Day) <u>18</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 14th., 1865</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home.</u>		11. BIRTHPLACE (State or foreign country) <u>Webster, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>W. M. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Dr. W. E. Gattens, Son Md. Washington St. Ext. Frostburg</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
153X IMMEDIATE CAUSE (A) <u>Carcinoma - sigmoid</u>		DUE TO		<u>Colon</u>		<u>Several Months</u>	
ANTECEDENT CAUSE(S) (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		DUE TO					
STATING UNDERLYING CAUSE LAST (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>  </u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>July 1, 1953</u> <b>to</b> <u>Sept 14, 1955</u> <b>that I last saw the deceased alive on</b> <u>Sept 14, 1955</u> <b>and that death occurred at</b> <u>9:00 P.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>W. E. Gattens</u> <b>ADDRESS</b> (Street, city, town, state) <u>Frostburg, Md.</u> <b>DATE SIGNED</b> <u>9-19-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-20-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		LOCATION (City, town, or county) (State) <u>Barton Md.</u>	
24. REC'D BY REGISTRAR <u>9-20-55</u>		REGISTRAR'S SIGNATURE <u>Nancy H. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pearl H. Mattingly</u>		ADDRESS <u>Frostburg Md.</u>	

# CERTIFICATE OF DEATH

9254

1. NAME OF DECEASED		2. PLACE OF DEATH	
JAMES ALLEN JONES		BALTIMORE, MARYLAND	
3. SEX		4. AGE	
Male		35	
5. RACE		6. OCCUPATION	
White		Teacher	
7. DATE OF DEATH		8. TIME OF DEATH	
April 15, 1955		10:30 AM	
9. CAUSE OF DEATH		10. MANNER OF DEATH	
Myocardial Infarction		Natural	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
J. H. Smith, M.D.		[Signature]	

13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED	
[Signature]		[Signature]	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
[Signature]		[Signature]	

BUREAU V. 2

525 28 1955

RECEIVED

SHORT-CUTS

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

1. Within corporate limits:

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08264

# CERTIFICATE OF DEATH

8248

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 3 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		Rural X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.				STREET ADDRESS RT.#1, HOMEWOOD ADDITION			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARGARET		(Middle) GORDON		(Lest)		(Year) 19 55	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH MAY 7, 1903	
9. AGE last birthday 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN POWELL				14. MOTHER'S MAIDEN NAME FRANCES GRIFFITHS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Harvey Gordon, Cumberland Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
416X IMMEDIATE CAUSE (A) Rheumatic Heart disease				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) myocardial failure							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 7, 1955, to Sept 10, 1955, that I last saw the deceased alive on Sept 10, 1955, and that death occurred at 7:15 A.M. from the causes and on the date stated above.							
SIGNATURE George M. Brown		M.D. Cumberland Md.		DATE SIGNED Sept 11, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-13-55		NAME OF CEMETERY OR CREMATORY L. yborger		LOCATION (City, town, or county) (State) Buffalo Mills Pa.	
24. REC'D BY REGISTRAR Sept. 12, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler		ADDRESS Hyndman Pa.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

40820

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased (Print or Print Name)

2. Name of informant (Print or Print Name)  
3. Address of informant (Print or Print Name)

4. Date of death (Print or Print Name)

5. Place of death (Print or Print Name)

6. Cause of death (Print or Print Name)

7. Manner of death (Print or Print Name)

8. Signature of informant (Print or Print Name)

9. Signature of physician (Print or Print Name)

10. Signature of coroner (Print or Print Name)

11. Signature of registrar (Print or Print Name)

12. Signature of clerk (Print or Print Name)

13. Signature of auditor (Print or Print Name)

14. Signature of treasurer (Print or Print Name)

15. Signature of controller (Print or Print Name)

16. Signature of comptroller (Print or Print Name)

17. Signature of secretary (Print or Print Name)

18. Signature of assistant secretary (Print or Print Name)

19. Signature of chief clerk (Print or Print Name)

20. Signature of deputy chief clerk (Print or Print Name)

21. Signature of assistant deputy chief clerk (Print or Print Name)

22. Signature of clerk in charge (Print or Print Name)

1. Name of deceased (Print or Print Name)

2. Name of informant (Print or Print Name)  
3. Address of informant (Print or Print Name)

4. Date of death (Print or Print Name)

5. Place of death (Print or Print Name)

6. Cause of death (Print or Print Name)

7. Manner of death (Print or Print Name)

8. Signature of informant (Print or Print Name)

9. Signature of physician (Print or Print Name)

10. Signature of coroner (Print or Print Name)

11. Signature of registrar (Print or Print Name)

12. Signature of clerk (Print or Print Name)

13. Signature of auditor (Print or Print Name)

14. Signature of treasurer (Print or Print Name)

15. Signature of controller (Print or Print Name)

16. Signature of comptroller (Print or Print Name)

17. Signature of secretary (Print or Print Name)

18. Signature of assistant secretary (Print or Print Name)

19. Signature of chief clerk (Print or Print Name)

20. Signature of deputy chief clerk (Print or Print Name)

21. Signature of assistant deputy chief clerk (Print or Print Name)

22. Signature of clerk in charge (Print or Print Name)

BUREAU V. B.

EP 15 1955

George M. Brown - Coroner  
John J. Brown - Registrar  
John J. Brown - Clerk  
John J. Brown - Auditor  
John J. Brown - Treasurer  
John J. Brown - Controller  
John J. Brown - Comptroller  
John J. Brown - Secretary  
John J. Brown - Assistant Secretary  
John J. Brown - Chief Clerk  
John J. Brown - Deputy Chief Clerk  
John J. Brown - Assistant Deputy Chief Clerk  
John J. Brown - Clerk in Charge

SMOOTHLETTER



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

08265

Reg. Dist. No. 4

8249

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ALLEGANY</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>ALLEGANY</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
02 TOWN <u>CUMBERLAND</u>	12 days	TOWN <u>CUMBERLAND</u>	02
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
62 <u>SACRED HEART HOSPITAL</u>		<u>518 LOUISIANA AVENUE</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>JOHN</u> <u>FRIDEN</u> <u>GRIFFITH</u>		<u>9-30-55</u> 19	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>11-25-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Ret. Engineer</u>		<u>West-Md. R.R.</u>	<u>WEST VIRGINIA</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>CHARLES GRIFFITH</u>		<u>ELIZABETH Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>None</u>		<u>CHART</u>	
17. INFORMANT & ADDRESS			
<u>410</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
162X IMMEDIATE CAUSE (A)		<u>Bronchogenic Carcinoma</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1st 55</u> to <u>Sept 30, 55</u> , that I last saw the deceased alive on <u>Sept 29, 55</u> , and that death occurred at <u>7:55 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>R. T. Treaskie, Jr.</u>		ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>	
DATE SIGNED <u>9/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>Oct. 2, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Hillcrest Bur. Park</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Walter L. Haug, M.D.</u>		<u>John J. Hafer, Cumberland, Maryland</u>	
DATE <u>Oct. 1, 1955</u>			

CERTIFICATE OF DEATH

1. COUNTY (Indicate county of residence)

2. DATE OF DEATH (Indicate day, month, and year)

3. PLACE OF DEATH (Indicate street, city, and state)

4. NAME OF DECEASED (Indicate full name)

5. SEX (Indicate male or female)

6. AGE (Indicate years and months)

7. OCCUPATION (Indicate occupation)

8. CAUSE OF DEATH (Indicate cause of death)

9. MANNER OF DEATH (Indicate manner of death)

10. SIGNATURE OF PHYSICIAN (Indicate signature)

11. SIGNATURE OF REGISTRAR (Indicate signature)

12. SIGNATURE OF WITNESS (Indicate signature)

13. SIGNATURE OF DECEASED (Indicate signature)

BUREAU V. 3

OCT 4 1955

RECEIVED

NOTICE TO THE PUBLIC: This certificate is a legal document and must be filed with the proper authorities. It is the duty of the registrars to see that this certificate is properly filled out and signed. The information on this certificate is used for the purpose of determining the cause of death and for the purpose of determining the age of the deceased. It is also used for the purpose of determining the date of death. The information on this certificate is also used for the purpose of determining the place of death. It is the duty of the registrars to see that this certificate is properly filled out and signed. The information on this certificate is used for the purpose of determining the cause of death and for the purpose of determining the age of the deceased. It is also used for the purpose of determining the date of death. The information on this certificate is also used for the purpose of determining the place of death. It is the duty of the registrars to see that this certificate is properly filled out and signed.

8250

08266

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>Bedford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>				CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cumberland</u> (rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Sacred Heart Hospital.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. #3</u> <u>75X-3</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Melvin</u> <u>Wilson</u> <u>Growden</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept.</u> <u>12</u> <u>19</u> <u>55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>July-15-1912</u>	9. AGE last birthday: <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Contract Hauler</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Howell Coal Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Bedford Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Growden</u>				14. MOTHER'S MAIDEN NAME: <u>Ettie Hardman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <u>2/10</u>		16. SOCIAL SECURITY No.: <u>220-10-1372</u>		17. INFORMANT & ADDRESS: <u>Cumberland, Md.</u> <u>(wife) Mary Myrtle Growden, R.F.D. #3</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a)..... <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b)..... <u>Coronary sclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <u>Chronic myocarditis</u>						<u>sudden</u> <u>about 5</u> <u>years</u> <u>about 5</u> <u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
<u>H.V. Deming M.D.</u>		<u>H. V. Deming M.D.</u> M. D. <u>Sept. 12-1955</u>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 15, 1955</u>		<u>Friendship Cemetery</u>		<u>Centerville, Pennsylvania</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 14, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>John J. Rafer</u>		<u>Cumberland, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

SEP 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN <u>Cumberland</u>		<u>2 days</u>	TOWN (rural) <u>Cumberland</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>			STREET ADDRESS (If rural, give location) <u>R.P.D.#6 Locust Grove</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
<u>Mazie</u>	<u>Ellen</u>	<u>Hendrickson</u>	<u>Sept.</u>	<u>2</u>	<u>1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:		9. AGE last birthday:
<u>female</u>	<u>white</u>	<u>Widow</u>	<u>Feb. 11-1865</u>		<u>90</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>		<u>None</u>	<u>Near- Artemas, Pa.</u>		<u>U.S.A.</u>
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>James Smith</u>			<u>Phoebe Cooper</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
<u>no</u>		<u>none</u>	<u>(son) Paul Hendrickson, Cumberland, Md.</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
Immediate cause (a) <u>Uremia due to Anuria</u> Complete- Antecedent cause(s) (b) <u>Dehydration</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>also was blind (bilateral)</u>				<u>about 2 weeks</u> <u>2 days</u> <u>15 years</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
<u>Intertrochanteric fracture of left femur.</u>				<u>3 months</u>
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?
<u>9-4-1955</u>		<u>femur.</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)		
	<u>Home</u>	<u>Locust Grove Allegany Md.</u>		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
<u>May 26/55 A. M.</u>		<u>While dressing, legs gave away and she fell to the floor.</u>		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE		CHIEF MEDICAL EXAMINER		
<u>H.V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER		
		ASSISTANT MEDICAL EXAM.		
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		
<u>Burial</u>		<u>9-4-1955</u>		
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)		
<u>Hillcrest Cem.</u>		<u>Cumberland, Md.</u>		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR
<u>Sept. 3, 1955</u>		<u>Walter R. Frank, M.D.</u>		<u>Charles L. George - Cumberland, Md.</u>
				ADDRESS
				<u>George</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 8 1955  
BUREAU V. S.



8252

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE W. VA.		COUNTY MINERAL	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
03 CUMBERLAND		8 DAYS		RIDGELEY,		85X.3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL MEMORIAL AVE.				RT.#1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
MR. GEORGE Edward HUTT				SEPT. 15 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	DEC. 26, 1900	54 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Electrician		Celanese		XXXXXXXXXX Indiana		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
OTIS HUTT				RB RHODA COX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		217-10-5331		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
340.3 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						7 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						5 days	
STATING UNDERLYING CAUSE LAST. DUE TO						10 days	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. at work Not while at work					
22. I hereby certify that I attended the deceased from Sept. 7, 1955, to Sept. 15, 1955, that I last saw the deceased alive on Sept. 15, 1955, and that death occurred at 8:58 PM, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Clayton L. Lunn				9/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Sept. 18, 1955		Greenmount Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 17, 1955		Walter R. Frantz, M.D.		Charles L. George, Cumberland, Md.			

## INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

RECEIVED

SEP 20 1955

BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

18508

NAME OF DECEASED WILLIAM J. BLOOM		DATE OF DEATH OCT 28 1955		PLACE OF DEATH HOSPITAL	
AGE 65		SEX MALE		RACE WHITE	
BIRTH DATE OCT 28 1890		BIRTH PLACE BALTIMORE, MARYLAND		MARRIAGE MARRIED	
OCCUPATION RETIRED		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. BLOOM	
SIGNATURE OF NEXT OF KIN J. BLOOM		SIGNATURE OF MINISTER J. BLOOM		SIGNATURE OF CLERK J. BLOOM	

RECEIVED  
SEP 20 1955  
BUREAU V. S.

8253

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>7 Days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>128 Frederick St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Helen</u> (Middle) <u>Ellen</u> (Last) <u>Johnston</u>				(Month) <u>Sept.</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Separated</u>	<u>June 10 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Maternal Nurse</u>			<u>Nursing Sick</u>		<u>Berkeley Springs W. Va.</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Johnston</u>				<u>Rebecca (Snider) Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Sister Mrs Agnes Wilbert Cumberland</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A)				<u>Coronary Occlusion</u>		<u>7 Da.</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic Heart Disease</u>		<u>15 Yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Acute myocardial Infarction</u>		<u>7 Da.</u>	
STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Generalized Arteriosclerosis</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>		<u>None</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>None</u>		<u>None</u>		<u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<u>None</u>		<u>None</u>		<u>None</u>			
22. I hereby certify that I attended the deceased from <u>Sept 13, 1955</u> to <u>Sept 20, 1955</u> , that I last saw the deceased alive on <u>Sept 20, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Hallinan MD</u>				ADDRESS (Street, city, town, state) <u>140 Bedford St. Cumberland, Md.</u>		DATE SIGNED <u>9-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 23 1955</u>		<u>Greenway Cemetery</u>		<u>Berkeley Spring W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept 22, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>J. H. H. Light</u>		<u>Cumberland, Md.</u>	

**INSTRUCTIONS -**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-35 10M

# CERTIFICATE OF DEATH

Reg. Form No. 1

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF COURT

18. SIGNATURE OF STATE

19. SIGNATURE OF COUNTY

20. SIGNATURE OF CITY

21. SIGNATURE OF TOWNSHIP

22. SIGNATURE OF PARISH

23. SIGNATURE OF VILLAGE

24. SIGNATURE OF HAMLET

25. SIGNATURE OF CENSUS TRACT

26. SIGNATURE OF BLOCK

27. SIGNATURE OF HOUSEHOLD

28. SIGNATURE OF ROOM

29. SIGNATURE OF BED

30. SIGNATURE OF CHAIR

31. SIGNATURE OF TABLE

32. SIGNATURE OF CUPBOARD

33. SIGNATURE OF DRAWER

34. SIGNATURE OF DOOR

35. SIGNATURE OF WINDOW

36. SIGNATURE OF FLOOR

37. SIGNATURE OF CEILING

38. SIGNATURE OF WALL

39. SIGNATURE OF ROOF

40. SIGNATURE OF GROUND

41. SIGNATURE OF AIR

42. SIGNATURE OF WATER

43. SIGNATURE OF FIRE

44. SIGNATURE OF LIGHT

45. SIGNATURE OF SOUND

46. SIGNATURE OF SMELL

47. SIGNATURE OF TASTE

48. SIGNATURE OF TOUCH

49. SIGNATURE OF FEELING

50. SIGNATURE OF THOUGHT

51. SIGNATURE OF EMOTION

52. SIGNATURE OF ACTION

53. SIGNATURE OF REACTION

54. SIGNATURE OF RESPONSE

55. SIGNATURE OF BEHAVIOR

56. SIGNATURE OF CHARACTER

57. SIGNATURE OF PERSONALITY

58. SIGNATURE OF IDENTITY

59. SIGNATURE OF UNiqueness

60. SIGNATURE OF Individuality

61. SIGNATURE OF Selfhood

62. SIGNATURE OF Beingness

63. SIGNATURE OF Existence

64. SIGNATURE OF Reality

65. SIGNATURE OF Truth

66. SIGNATURE OF Justice

67. SIGNATURE OF Goodness

68. SIGNATURE OF Beauty

69. SIGNATURE OF Harmony

70. SIGNATURE OF Peace

71. SIGNATURE OF Love

72. SIGNATURE OF Compassion

73. SIGNATURE OF Kindness

74. SIGNATURE OF Gentleness

75. SIGNATURE OF Meekness

76. SIGNATURE OF Patience

77. SIGNATURE OF Forgiveness

78. SIGNATURE OF Longsuffering

79. SIGNATURE OF Mildness

80. SIGNATURE OF Sweetness

81. SIGNATURE OF Goodwill

82. SIGNATURE OF Favorable Disposition

83. SIGNATURE OF Pleasantness

84. SIGNATURE OF Agreeableness

85. SIGNATURE OF Sociableness

86. SIGNATURE OF Friendliness

87. SIGNATURE OF Hospitality

88. SIGNATURE OF Generosity

89. SIGNATURE OF Liberality

90. SIGNATURE OF Openhandedness

91. SIGNATURE OF Unselfishness

92. SIGNATURE OF Selflessness

93. SIGNATURE OF Altruism

94. SIGNATURE OF Philanthropy

95. SIGNATURE OF Beneficence

96. SIGNATURE OF Goodwill

97. SIGNATURE OF Kindness

98. SIGNATURE OF Gentleness

99. SIGNATURE OF Meekness

100. SIGNATURE OF Patience

101. SIGNATURE OF Forgiveness

102. SIGNATURE OF Longsuffering

103. SIGNATURE OF Mildness

104. SIGNATURE OF Sweetness

105. SIGNATURE OF Goodwill

106. SIGNATURE OF Favorable Disposition

107. SIGNATURE OF Pleasantness

108. SIGNATURE OF Agreeableness

109. SIGNATURE OF Sociableness

110. SIGNATURE OF Friendliness

111. SIGNATURE OF Hospitality

112. SIGNATURE OF Generosity

113. SIGNATURE OF Liberality

114. SIGNATURE OF Openhandedness

115. SIGNATURE OF Unselfishness

116. SIGNATURE OF Selflessness

117. SIGNATURE OF Altruism

118. SIGNATURE OF Philanthropy

119. SIGNATURE OF Beneficence

120. SIGNATURE OF Goodwill

121. SIGNATURE OF Kindness

122. SIGNATURE OF Gentleness

123. SIGNATURE OF Meekness

124. SIGNATURE OF Patience

125. SIGNATURE OF Forgiveness

126. SIGNATURE OF Longsuffering

127. SIGNATURE OF Mildness

128. SIGNATURE OF Sweetness

129. SIGNATURE OF Goodwill

130. SIGNATURE OF Favorable Disposition

131. SIGNATURE OF Pleasantness

132. SIGNATURE OF Agreeableness

133. SIGNATURE OF Sociableness

134. SIGNATURE OF Friendliness

135. SIGNATURE OF Hospitality

136. SIGNATURE OF Generosity

137. SIGNATURE OF Liberality

138. SIGNATURE OF Openhandedness

139. SIGNATURE OF Unselfishness

140. SIGNATURE OF Selflessness

141. SIGNATURE OF Altruism

142. SIGNATURE OF Philanthropy

143. SIGNATURE OF Beneficence

144. SIGNATURE OF Goodwill

145. SIGNATURE OF Kindness

146. SIGNATURE OF Gentleness

147. SIGNATURE OF Meekness

148. SIGNATURE OF Patience

149. SIGNATURE OF Forgiveness

150. SIGNATURE OF Longsuffering

151. SIGNATURE OF Mildness

152. SIGNATURE OF Sweetness

153. SIGNATURE OF Goodwill

154. SIGNATURE OF Favorable Disposition

155. SIGNATURE OF Pleasantness

156. SIGNATURE OF Agreeableness

157. SIGNATURE OF Sociableness

158. SIGNATURE OF Friendliness

159. SIGNATURE OF Hospitality

160. SIGNATURE OF Generosity

161. SIGNATURE OF Liberality

162. SIGNATURE OF Openhandedness

163. SIGNATURE OF Unselfishness

164. SIGNATURE OF Selflessness

165. SIGNATURE OF Altruism

166. SIGNATURE OF Philanthropy

167. SIGNATURE OF Beneficence

168. SIGNATURE OF Goodwill

169. SIGNATURE OF Kindness

170. SIGNATURE OF Gentleness

171. SIGNATURE OF Meekness

172. SIGNATURE OF Patience

173. SIGNATURE OF Forgiveness

174. SIGNATURE OF Longsuffering

175. SIGNATURE OF Mildness

176. SIGNATURE OF Sweetness

177. SIGNATURE OF Goodwill

178. SIGNATURE OF Favorable Disposition

179. SIGNATURE OF Pleasantness

180. SIGNATURE OF Agreeableness

181. SIGNATURE OF Sociableness

182. SIGNATURE OF Friendliness

183. SIGNATURE OF Hospitality

184. SIGNATURE OF Generosity

185. SIGNATURE OF Liberality

186. SIGNATURE OF Openhandedness

187. SIGNATURE OF Unselfishness

188. SIGNATURE OF Selflessness

189. SIGNATURE OF Altruism

190. SIGNATURE OF Philanthropy

191. SIGNATURE OF Beneficence

192. SIGNATURE OF Goodwill

193. SIGNATURE OF Kindness

194. SIGNATURE OF Gentleness

195. SIGNATURE OF Meekness

196. SIGNATURE OF Patience

197. SIGNATURE OF Forgiveness

198. SIGNATURE OF Longsuffering

199. SIGNATURE OF Mildness

200. SIGNATURE OF Sweetness

201. SIGNATURE OF Goodwill

202. SIGNATURE OF Favorable Disposition

203. SIGNATURE OF Pleasantness

204. SIGNATURE OF Agreeableness

205. SIGNATURE OF Sociableness

206. SIGNATURE OF Friendliness

207. SIGNATURE OF Hospitality

208. SIGNATURE OF Generosity

209. SIGNATURE OF Liberality

210. SIGNATURE OF Openhandedness

211. SIGNATURE OF Unselfishness

212. SIGNATURE OF Selflessness

213. SIGNATURE OF Altruism

214. SIGNATURE OF Philanthropy

215. SIGNATURE OF Beneficence

216. SIGNATURE OF Goodwill

217. SIGNATURE OF Kindness

218. SIGNATURE OF Gentleness

219. SIGNATURE OF Meekness

220. SIGNATURE OF Patience

221. SIGNATURE OF Forgiveness

222. SIGNATURE OF Longsuffering

223. SIGNATURE OF Mildness

224. SIGNATURE OF Sweetness

225. SIGNATURE OF Goodwill

226. SIGNATURE OF Favorable Disposition

227. SIGNATURE OF Pleasantness

228. SIGNATURE OF Agreeableness

229. SIGNATURE OF Sociableness

230. SIGNATURE OF Friendliness

231. SIGNATURE OF Hospitality

232. SIGNATURE OF Generosity

233. SIGNATURE OF Liberality

234. SIGNATURE OF Openhandedness

235. SIGNATURE OF Unselfishness

236. SIGNATURE OF Selflessness

237. SIGNATURE OF Altruism

238. SIGNATURE OF Philanthropy

239. SIGNATURE OF Beneficence

240. SIGNATURE OF Goodwill

241. SIGNATURE OF Kindness

242. SIGNATURE OF Gentleness

243. SIGNATURE OF Meekness

244. SIGNATURE OF Patience

245. SIGNATURE OF Forgiveness

246. SIGNATURE OF Longsuffering

247. SIGNATURE OF Mildness

248. SIGNATURE OF Sweetness

249. SIGNATURE OF Goodwill

250. SIGNATURE OF Favorable Disposition

251. SIGNATURE OF Pleasantness

252. SIGNATURE OF Agreeableness

253. SIGNATURE OF Sociableness

254. SIGNATURE OF Friendliness

255. SIGNATURE OF Hospitality

256. SIGNATURE OF Generosity

257. SIGNATURE OF Liberality

258. SIGNATURE OF Openhandedness

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8284

## CERTIFICATE OF DEATH

08270

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Md.</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>22 Frostburg</u>		Life time		TOWN <u>22 Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>61 Miner's Hospital</u>				<u>6 Grant Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<u>Carrie M. Keiling</u>				<u>9 20 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>4-8-1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Own Home</u>		<u>Zihlman, Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel H. Harden</u>				<u>Josephine Moser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>160 Mt. Pleasant St</u> <u>Mrs. James V. Miller, Daughter</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>260X</u> IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/53</u> , 19....., to <u>9/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>55</u> , and that death occurred at <u>5:15A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John C. Claver</u>				ADDRESS (Street, city, town, state) <u>Frostburg Md.</u>		DATE SIGNED <u>9/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-22-1955</u>		<u>Frostburg Memorial</u>		<u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>9-23-55</u>		<u>Mrs. Nancy N. Roe</u>		<u>Pearl H. Mattingly, Frostburg</u>		<u>Md.</u>	



CERTIFICATE OF DEATH

8224

DATE OF DEATH

A. USUAL RESIDENCE (HOME OR PLACE)

PLACE OF DEATH

NAME OF DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF HOSPITAL

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

NAME OF DECEASED

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DATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

BUREAU V. 2

SEP 27 1955

RECEIVED

INSTRUCTIONS



8293

08271

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 6

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Rural) Rawlings</u>	LENGTH OF STAY (in this place) <u>27 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Rural) Rawlings (Black Oak Farm)</u>	<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac River, half way between Rawlings &amp; Dawson., Md.</u>			STREET ADDRESS (If rural, give location) <u>R.F.D. #3 Keyser, W. Va.</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) <u>Raymond</u>	(Middle) <u>Forest</u>	(Last) <u>Kile</u>	(Month) <u>Sept.</u>	(Day) <u>18</u>	(Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>July 29-1928</u>		9. AGE last birthday: <u>27</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): <u>Tractor driver</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>B&amp;O. R. Ry.</u>		11. BIRTHPLACE (State or foreign country): <u>Black Oak Farm, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME: <u>Loy T. Kile</u>			14. MOTHER'S MAIDEN NAME: <u>Mary Hazel Kimble</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>Korea</u>			16. SOCIAL SECURITY No.: <u>234-44-6741</u>		
			17. INFORMANT & ADDRESS: <u>R.F.D #3 Keyser, W. Va.</u>		
			<u>(father) Loy T. Kile, Black Oak Farm, Md.</u>		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
<u>929.8</u> Immediate cause (a) <u>Asphyxia</u> DUE TO Antecedent cause(s) (b) <u>accidental drowning</u> Diseases or conditions, if any, giving rise to the above cause (c) <u>stating underlying cause last</u> DUE TO			<u>sudden</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>Sept. 18-1955</u>			19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office, bldg., etc.) <u>Pot. River</u>	21c. (City or town) (County) <u>Near) Rawlings Allegany</u>	(State) <u>Md.</u>
21d. TIME (Month) (Day) (Year) <u>Sept. 18-1955 PM</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Drown while trying to save another person.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <u>Sept. 19-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>9-21-55</u>	NAME OF CEMETERY OR CREMATORY <u>Dawson, Cemetery</u>	LOCATION (City, town, or county) (State) <u>Dawson, Md.</u>
DATE REC'D BY LOCAL REG. <u>Sept 22, 1955</u>	REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>	24. FUNERAL DIRECTOR ADDRESS <u>Rogers Funeral Home, Keyser, W. Va.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8285

08272

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>14 hrs.</u>		TOWN <u>Frostburg</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural, give location) <u>Spring St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Emma Lancaster</u>				<u>Sept. 14 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 5-1881</u>	
9. AGE last birthday: <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Rawlings, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Levi Robinson</u>				14. MOTHER'S MAIDEN NAME: <u>Amanda Jackson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>(daughter) Cora Harriet, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Myocardial infarction</u>						?	
DUE TO						about 1	
Antecedent cause(s) (b) <u>Coronary occlusion</u>						Hour.	
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u>also had Cardiac hypertrophy.</u>						?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>M.D.</u>		<u>Sept. 14-19</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9-16-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
DATE REC'D BY LOCAL REG. <u>9-16-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Roe</u>		24. FUNERAL DIRECTOR <u>Charles H. Wittingly, Frostburg, Md.</u>		ADDRESS	

RECEIVED

SEP 20 1955

BUREAU V. 2

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8254

CERTIFICATE OF DEATH

08273

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>4 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>62 Sacred Heart Hospital</u>				<u>311 Avirett Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>Margaret</u> (Last) <u>Lowery</u>				(Month) <u>9</u> (Day) <u>1</u> (Year) <u>26</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 3, 1887</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housework</u>		<u>Maryland Cumberland,</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Hoffman</u>				<u>Mary Felkner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>218-30-0591 A</u>		<u>Cumberland, Md.</u> <u>Mrs. David McMillan 311 Avirett Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>12 mos</u>	
420.0 IMMEDIATE CAUSE (A) <u>Atherosclerotic Heart Disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15</u> , 19 <u>54</u> , to <u>Sept 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>55</u> , and that death occurred at <u>3:45 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Rosa W. Baer</u>				<u>M.D. 62 Greene St., Cumberland Md</u>		<u>9-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/29/55</u>		<u>St. Lukes Cem.</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 28, 1955</u>		<u>Walter R. Jantz, M.D.</u>		<u>H. Wayne George</u>		<u>Cumberland, Md.</u>	





1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08275

8255

# CERTIFICATE OF DEATH

Item 12, Film G186 9-20-55 et

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>				TOWN <u>LONA CONING</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>SACRED HEART HOSPITAL</u>				<u>WATERCLIFF ST., BOX 382</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ANDREW MCDONALD</u>				<u>9-13-55</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>10-28-77</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>UNITED MINE WORKER</u>				<u>SCOTLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John McDonald</u>				<u>MARGARET Carlaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>216-07-2799</u>		<u>CHART</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.0 IMMEDIATE CAUSE (A)</u>				<u>Coronary Occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> 19 <u>55</u> , to <u>9/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>55</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>George Richardson</u> M.D.				ADDRESS (Street, city, town, state) <u>Lonaconing, Ind.</u>		DATE SIGNED <u>9-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 15, 1955</u>		<u>Oak Hill Cemetery</u>		<u>Lonaconing, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 14, 1955</u>		<u>Walter L. Frantz, M.D.</u>		<u>GEORGE EICHORN</u>		<u>Lonaconing, Ind.</u>	

# CERTIFICATE OF DEATH

Reg. No. 100

ALPHABETICALLY (FIRST OF LAST NAME)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

MARRIAGE

PREVIOUS MARRIAGES

PREVIOUS DEATHS

PREVIOUS ILLNESSES

PREVIOUS SURGERIES

PREVIOUS TRAUMAS

PREVIOUS ACCIDENTS

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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BUREAU V. S.

SEP 16 1955

RECEIVED

STATE DEPARTMENT OF HEALTH

BALTIMORE, MARYLAND

SEP 16 1955

RECEIVED

STATE DEPARTMENT OF HEALTH

BALTIMORE, MARYLAND

SEP 16 1955

RECEIVED

1. Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08276

8294

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cresaptown</u>		9 yrs.		TOWN <u>Cresaptown</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ROBERT ARTHUR MC INTOSH				Sept. 29, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	June 30, 1881	74 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		General Farming		Woodstock, Virginia.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Mc Intosh				Mary Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Mrs. Sadie McKenzie, Cresaptown, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4200 IMMEDIATE CAUSE (A) <u>congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>transverse myelitis for 40 years</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-4</u> 19 <u>55</u> , to <u>9-29</u> 19 <u>55</u> , that I last saw the deceased alive on <u>9-28</u> 19 <u>55</u> , and that death occurred at <u>10:25</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. H. H. H.</u>				DATE SIGNED <u>10-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		October 2, 1955		Burlington, W. Va., Cem		Burlington, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct. 1, 1955		Walter R. Frank, M.D.		John J. Hafer, Cumberland, Md.			

5578

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

# CERTIFICATE OF DEATH

Reg. No. 100

AT HANOVER, NEW HAMPSHIRE, ON

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARITAL STATUS  
PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO  
PREVIOUS OTHER

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARITAL STATUS  
PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO  
PREVIOUS OTHER

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARITAL STATUS  
PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO  
PREVIOUS OTHER

DATE OF DEATH  
PLACE OF DEATH  
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BUREAU V. 2

OCT 4 1955

RECEIVED

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1. This certificate is to be filled out by the attending physician or other qualified person who has attended the deceased during the last illness. It should be filled out as soon as possible after death, and should be signed by the physician or other qualified person who has attended the deceased during the last illness. It should be filed in the office of the Registrar of Vital Statistics, or in the office of the health officer of the city or town in which the deceased resided at the time of death. It should be retained for a period of ten years after the date of death.

8256

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND, MARYLAND		82 DAYS		TOWN CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL				7 CRESAP STREET			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
BEULAH MILLER				9 20 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	JUNE 17, 1891	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Ownhome		WEST VIRGINIA, Hampshire Co.		U.S.A. USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DAVID BEAN				GERTRUDE SINDY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		MEMORIAL HOSPITAL, MEMORIAL AVENUE			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				Carcinoma of breast			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Carcinoma of breast			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
11/22/54		Carcinoma of breast		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 30, 1953, to Sept. 20, 1953, that I last saw the deceased alive on Sept. 9, 1953, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
J. E. Linder				Cumberland		9/22/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-23-55		Indian Mount Cem		Romney, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 23, 1955		Winter R. Frantz, M.D.		James F. Scarpelli		Cumberland, Md	

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



108332

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

8555

DATE OF DEATH

1. NAME OF DECEASED

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SEX AND

DATE OF BIRTH

IN BIRTH

GREENLAND, WYOMING AS DAYS

1-CHURCH STREET

MEMORIAL HOSPITAL

ILLER

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DATE OF DEATH

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MEMORIAL HOSPITAL, MEMORIAL AVENUE

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BUREAU V. B.

SEP 26 1955

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CHIEF OF BUREAU



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		<u>7 yrs.</u>		TOWN <u>Westport</u> <u>43</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>			STREET ADDRESS (If rural, give location) <u>1</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) <u>Charles</u> (Middle) <u>Robert</u> (Last) <u>Miller</u>			(Month) <u>Sept.</u> (Day) <u>27</u> (Year) <u>19 55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>Single</u>	<u>March ? 1879</u>	<u>76</u> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired Coal Miner</u>		<u>Mining coal</u>		<u>Westernport, Md.</u>	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>John Miller</u>			<u>Mary Duckworth</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>		<u>None</u>		<u>Allegany Co. Infirmary records.</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			<u>16 hrs.</u>	
<u>900.7</u> Immediate cause (a) <u>Intracranial hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>a fractured skull.</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?
<u>2</u>		<u>Concrete walk.</u>		<u>Yes</u> <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF INJURY <u>at work</u> )	21c. (City or town) (County) (State)	<u>Cumberland Allegany 01 Md.</u>	
21d. TIME (Month) (Day) (Year) <u>Sept. 26-P.</u> (Hour) <u>3</u> (M.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Ascending out side steps, mis-step, fell backward &amp; hit head on concrete walk.</u>		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Sept. 27/55</u>		
<u>H.V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
<u>M.D.</u>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>Sept. 29, 1955</u>	<u>Bellevue Cemetery</u>	<u>Westport, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Sept. 28, 1955</u>	<u>Walter K. Brant, M.D.</u>	<u>Boala Funeral Home, Westport, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

SEP 29 1955

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Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08279

8258

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>47 Marion Street</u>				STREET ADDRESS (If rural give location) <u>47 Marion Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MALINDA</u>		(Middle) <u>JANE</u>		(Last) <u>MORSE</u>		(Month) (Day) (Year) <u>Sept. 20 19 55</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 4, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseworker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Allegany County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Austin Hartsock</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Robinette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-0762</u>		17. INFORMANT & ADDRESS <u>John A. Morse, Cumberland, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Heart Disease</u>				<u>30 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>				<u>20 yr.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>none</u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-5-1955</u> to <u>Sept. 20, 19 55</u> , that I last saw the deceased alive on <u>Sept. 20, 19 55</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Hallinan</u>		DATE THEREOF <u>Sep. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cem.</u>		LOCATION (City, town, or county) (State) <u>Artemas, Pennsylvania</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sep. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cem.</u>		LOCATION (City, town, or county) (State) <u>Artemas, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>Sept. 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter L. Rautz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 115C 7-55 10M

BUREAU V. S.

SEP 23 1965

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08280

8286

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>				TOWN <u>Frostburg</u>		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miners Hospital</u>				<u>60 Mechanic Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>AGNES (WALKER) MUIR</u>				<u>Sept. 20, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>Married</u>	<u>Oct. 8, 1883</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housework</u>		<u>own home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Walker</u>				<u>Agnes Speir</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>James Muir, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A)				<u>Cerebral Vas. Accident</u>		<u>48 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Pulmonary Fibrosis &amp; Emphysema</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Congestive Heart Failure</u>			
STATING UNDERLYING CAUSE LAST. DUE TO				<u>Arteriosclerosis</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>9/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>55</u> , and that death occurred at <u>8 P</u> .M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John C. [Signature]</u>				<u>Frostburg</u>		<u>9/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>9-23-1955</u>		<u>Frostburg Memorial Park</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>9-22-55</u>		<u>John [Signature]</u>		<u>J. R. Durst</u>		<u>Frostburg, Md.</u>	

10-22-50

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

8228

Form 10-1-50

1. Usual Residence of Deceased

2. Place of Death

3. Date of Death

4. Time of Death

5. Cause of Death

6. Manner of Death

7. Age at Death

8. Sex

9. Race

10. Marital Status

11. Occupation

12. Education

13. Date of Birth

14. Place of Birth

15. Date of Admission to Hospital

16. Date of Discharge

17. Date of Death

18. Date of Death

19. Date of Death

20. Date of Death

21. Date of Death

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60. Date of Death

BUREAU V. B.

1955

RECEIVED

DEPARTMENT OF HEALTH



**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08281

8287

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Md.</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
22 TOWN <u>Frostburg</u>		5 Mos.		TOWN <u>Frostburg</u>		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miners Hospital</u>				201 Center St.			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Robert</u> (Middle) <u>Muir</u> (Last) <u>Muir</u>				(Month) <u>9</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	4-28-1885	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Minor		Coal		Moscow		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S M maiden NAME			
<u>Michael Muir</u>				<u>Tilford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				201 Center St. City			
				<u>Mr. Clarence Muir, Son</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
525 X IMMEDIATE CAUSE (A) <u>Pulmonary Fibrosis + Emphysema</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Failure</u>						10 YRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>MARCH</u> , 19 <u>55</u> , to <u>SEPT</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>55</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John C. Devers</u>				ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>9/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-23-55		Frostburg Memorial		Frostburg Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>9-23-55</u>		<u>Mr. Nancy M. Rice</u>		<u>Pearl H. Muntz</u>		<u>Frostburg Md</u>	



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8295

## CERTIFICATE OF DEATH

08282

Item 9, Film G186 9-19-55 et

Reg. Dist. No. 10

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>					
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Savage</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Savage,</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS <u>Railroad Street</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Cecilia Mary Mullaney</u>							
<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>9 - 11 19 55</u>							
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widow</u>	<b>8. DATE OF BIRTH</b> <u>11-24-1864</u>				
<b>9. AGE last birthday</b> <u>90</u> yrs.		<b>10. AGE last birthday</b> <u>90</u> yrs.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housework</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>					
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mt. Savage, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Martin Carabine</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine McQuade</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Chas. F. Mullaney, Mt. Savage, Md.</u>					
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>					
<b>IMMEDIATE CAUSE (A)</b> <u>Acute Heart Failure</u>		<u>4 days</u>					
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Serious</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>					
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>							
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)</b> <u>M.</u>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>					
<b>21f. HOW DID INJURY OCCUR?</b>							
<b>22. I hereby certify that I attended the deceased from <u>Sept 8, 1955</u>, to <u>Sept 11, 1955</u>, that I last saw the deceased alive on <u>Sept 8, 1955</u>, and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>I. M. G. Murray</u> M.D.		<b>DATE SIGNED</b> <u>Sept 12/55</u>					
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>9-14-1955</u>					
<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Patrick's Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Mt. Savage, Md.</u>					
<b>24. REC'D BY REGISTRAR</b> <u>Veronica M. Dermott</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. R. Durst</u>					
<b>DATE</b> <u>9-13-1955</u>		<b>ADDRESS</b> <u>Frostburg, Md.</u>					



**INSTRUCTIONS**

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**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8259

# CERTIFICATE OF DEATH

08283

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>	LENGTH OF STAY (in this place)	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>320 Waverly Terrace</u>		STREET ADDRESS (If rural give location) <u>320 Waverly Terrace</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MARTHA JANE NEWELL</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 17</u> <u>1955</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowd</u>	<b>8. DATE OF BIRTH</b> <u>Sept. 5, 1871</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	<b>9. AGE last birthday</b> <u>84</u> yrs.
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Twiggstown, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>GEORGE RICE</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>RACHAEL WILLISON</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. J. Wm. Wagner, Cumberland, Md</u>			
<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <u>Cerebral hemorrhage</u>			<u>5 days</u>
<b>ANTECEDENT CAUSE(S) DUE TO</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <u>Arterial hypertension</u>			<u>2 years</u>
<b>(C)</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/></b>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Sept 12</u>, 19<u>55</u>, to <u>Sept 17</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Sept 17</u>, 19<u>55</u>, and that death occurred at <u>7 P</u>.M, from the causes and on the date stated above. <u>9/19/55</u></b>			
<b>SIGNATURE</b> <u>R. W. Dravaski, Jr</u>		<b>DATE SIGNED</b> <u>Cumberland, Maryland</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEROF</b> <u>Sept 20, 1955</u>	
<b>NAME OF CEMETERY OR CREMATORY</b> <u>Greenmount Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Cumberland, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Sept. 20, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Walter R. Hantz, M.D.</u>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Hafer</u>		<b>ADDRESS</b> <u>Cumberland, Maryland</u>	



# CERTIFICATE OF DEATH

1955

Year, Date, etc.

A. Medical Examination (Date of Death)

MARYLAND  
DEPARTMENT OF HEALTH  
BALTIMORE, MD.

1. Name of Deceased  
2. Sex  
3. Race  
4. Age  
5. Date of Birth  
6. Date of Death  
7. Place of Death  
8. Cause of Death  
9. Manner of Death  
10. Signature of Physician  
11. Signature of Registrar  
12. Signature of Medical Examiner  
13. Signature of Coroner  
14. Signature of Jury  
15. Signature of Judge  
16. Signature of District Attorney  
17. Signature of County Clerk  
18. Signature of Town Clerk  
19. Signature of School Board  
20. Signature of Board of Education  
21. Signature of Board of Health  
22. Signature of Board of Public Works  
23. Signature of Board of Police  
24. Signature of Board of Fire  
25. Signature of Board of Public Safety  
26. Signature of Board of Public Health  
27. Signature of Board of Public Welfare  
28. Signature of Board of Public Education  
29. Signature of Board of Public Safety  
30. Signature of Board of Public Health  
31. Signature of Board of Public Welfare  
32. Signature of Board of Public Education  
33. Signature of Board of Public Safety  
34. Signature of Board of Public Health  
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94. Signature of Board of Public Health  
95. Signature of Board of Public Welfare  
96. Signature of Board of Public Education  
97. Signature of Board of Public Safety  
98. Signature of Board of Public Health  
99. Signature of Board of Public Welfare  
100. Signature of Board of Public Education

1. Name of Deceased

*Robert James Adams*

2. Sex

*Male*

3. Race

*White*

4. Age

*45*

5. Date of Birth

*1910*

6. Date of Death

*1955*

7. Place of Death

*Home*

8. Cause of Death

*Heart Disease*

9. Manner of Death

*Natural*

BUREAU V. 3

SEP 21 1955

RECEIVED

*1955*

*1955*

*1955*

*1955*

*1955*

*1955*

*1955*



## CERTIFICATE OF DEATH

Reg. Dist. No. 4

8260

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Cumberland</b>				TOWN <b>Lonaconing</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>Sacred Heart Hospital</b>				<b>East Main Street</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<b>JESSIE NICHOLS</b>				<b>Sept, 16th 1955</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>May, 10th, 1878</b>	<b>77</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Housework</b>		<b>Own Home</b>		<b>Lonaconing, Md.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>John Heron</b>				<b>Jean Bradley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>4 No</b>		<b>None</b>		<b>Lindley P. Nichols (Husband)</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)				<b>Lonaconing, MD.</b>		<b>2d.</b>	
ANTECEDENT CAUSE(S) DUE TO				<b>Massive Pulmonary Emboli</b>		<b>4 weeks</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				<b>Thrombophlebitis</b>		<b>7 mo.</b>	
				<b>congestive heart failure</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 12, 1955</b> to <b>16 Sept, 1955</b> , that I last saw the deceased alive on <b>16 Sept, 1955</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>George R. Frantz, M.D.</b>				ADDRESS (Street, city, town, state) <b>Lonaconing, MD.</b>		DATE SIGNED <b>9-17-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sept, 22, 1955</b>		<b>Oak Hill Cemetery</b>		<b>Lonaconing, MD.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Sept. 21, 1955</b>		<b>Winter R. Frantz, M.D.</b>		<b>George Eichhorn, Lonaconing, MD.</b>			

**INSTRUCTIONS**

**1** **WITHIN OPERABLE LIMITS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

1955

NAME OF DECEASED	DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH
John Brown	1910, 10, 10	London, England	1955, 10, 10	London, England
CAUSE OF DEATH	SEX	AGE	EDUCATION	RELIGION
Heart Disease	Male	45	High School	Anglican
DATE OF BURIAL	PLACE OF BURIAL	NAME OF BURIAL PLACE	NAME OF MINISTER	NAME OF WITNESSES
1955, 10, 15	St. Paul's Church	St. Paul's Church	Rev. J. Smith	John Doe, Jane Doe

BUREAU V. S.

SEP 25 1955

RECEIVED

George Brown, London, England

8261

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		9 HRS. 15 MIN.		TOWN CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL				231 ARCH STREET			
MEMORIAL & WARWICK AVES.				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
FRANK H PADFIELD				SEPTEMBER 14, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	NOV. 27 25, 1890	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer - L. Bernstein Furniture Company						PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY?				U.S.A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN PADFIELD				MARY ALDOM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No				214-07-0519		Memorial Hospital, Cumberland, Maryland.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) Massive Cerebral Haemorrhage							
ANTECEDENT CAUSE(S) DUE TO Left Hemiplegia							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Hypertension							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 14, 1955, to Sept. 14, 1955, that I last saw the deceased alive on Sept. 14, 1955, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
Clayton J. Jurett				Cumberland			
M.D.				DATE SIGNED 9/15/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 17, 1955		Rose Hill Cemetery		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 17, 1955		Winter R. Trautz M.D.		James F. Scarpelli		Cumberland Md.	

INSTRUCTIONS

**1** Within corporate limits

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8288

## CERTIFICATE OF DEATH

08286

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Allegany</b>		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Frostburg</b>		<b>life</b>		TOWN <b>Frostburg St.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>19 Bowery St.</b>				STREET ADDRESS (If rural give location) <b>19 Bowery St.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>MARY</b>		(Middle) <b>M.</b>		(Last) <b>PHILLIPS</b>		(Month) (Day) (Year) <b>Sept. 8, 19 55</b>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Female</b>	<b>white</b>	<b>married</b>	<b>5-26-1880</b>	<b>75</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>housework</b>		<b>own home</b>		<b>Maryland</b>		<b>USA</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Wm. D. Morgan</b>				<b>Mary Ann Wilcox</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<b>none</b>		<b>Eli Phillips, Frostburg, Md.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>443X</b> IMMEDIATE CAUSE (A) <b>myocardial insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertension</b>						<b>Several years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Cerebral Hemorrhage</b>						<b>2 yrs</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>Nov 23, 19 53</b> , to <b>Sept 8, 19 55</b> , that I last saw the deceased alive on <b>Sept 8, 19 55</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Wm. C. Lane</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Frostburg Md</b>			
				<b>DATE SIGNED</b> <b>Sept 9 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<b>Burial</b>		<b>9-11-1955</b>		<b>F'bg. Memorial Park</b>		<b>Frostburg, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <b>9-11-55</b>		<b>Mrs. Nancy H. Ratz</b>		<b>J. R. Durst,</b>		<b>Frostburg, Md.</b>	







8262

# CERTIFICATE OF DEATH

DR. W. F. WILLIAMS

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		19 DAYS		TOWN CRESAPTOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location)			
60				439 McMullon Highway			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
RANAH ELIZABETH POWELL				DEATH SEPTEMBER 9, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	JANUARY 9, 1895	60 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			Own Home		WEST VIRGINIA		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
NELSON N. KELLY				Elizabeth Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
No			None		MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
252.0 IMMEDIATE CAUSE (A) Thyrotoxicosis severe						Approx 3 yrs.	
ANTECEDENT CAUSE(S) DUE TO Pneumonia, bronchial, bilateral						4 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO nephritis chronic with uremia						4 days	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Sep 2, 1955		Exoc adenomata thyroid gland					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 20, 1955, to Sep 9, 1955, that I last saw the deceased alive on Sep 8, 1955, and that death occurred at 3:05 A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
W. F. Williams				Sep 9 '55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 11, 1955		Powell Family Cemetery		near Augusta, West Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sep 10, 1955		Walter R. Hantz, M.D.		Rogers Funeral Home - Keiser			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

100-100000-1000

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10-10-2000 BY 100-100000-1000

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MR. J. F. WILLIAMS

8565

48884

1. PLACE OF DEATH

HOME

DATE OF DEATH

11 DAYS

CONSUMPTION

CHESAPEAKE HOSPITAL

AGE

RESIDENCE

RAMON

SEX

WHITE

STATUS

MARRIED

0

NO SCIENTIFIC

OWN

WEST VIRGINIA

WELDON H. KELLY

DEATH

DATE OF DEATH

1955

IN MEDICAL CERTIFICATION

CAUSE OF DEATH

CONSUMPTION

CHESAPEAKE HOSPITAL

DATE OF DEATH

11 DAYS

CONSUMPTION

CHESAPEAKE HOSPITAL

DATE OF DEATH

11 DAYS

CONSUMPTION

CHESAPEAKE HOSPITAL

DATE OF DEATH

11 DAYS

CONSUMPTION

CHESAPEAKE HOSPITAL

DATE OF DEATH

11 DAYS

CONSUMPTION

CHESAPEAKE HOSPITAL

BUREAU V.B.

SEP 15 1955

RECEIVED

8296

08282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 6

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
<u>X</u> TOWN <u>Rural-near Danville</u>		<u>30 Yrs.</u>	TOWN <u>Rural-near-Danville</u> <u>X</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)			
<u>R.F.D.#3 Keyser, W.Va.</u>		<u>R.F.D.#3 Keyser, W.Va.</u>			
3. NAME OF DECEASED:		(First)	(Middle)	(Last)	4. DATE OF DEATH
(Type or Print)		<u>Sarah</u>	<u>Rosella</u>	<u>Ravenscroft</u>	<u>Sept. 25 19 55</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	9. AGE last birthday:
<u>female</u>	<u>white</u>	<u>widow</u>		<u>Aug. 31-1878</u>	<u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>				<u>Avilton, Garrett Co, Md.</u>	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Andrew Jackson</u>			<u>Charlotte Dawson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>		<u>none</u>		<u>Keyser, W.Va.</u> <u>(daughter) Martha Ravenscroft, R.F.D.#3</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>443X</u> Immediate cause (a) <u>Myocardial failure</u>		<u>Gradual</u>
DUE TO		<u>over 2</u>
Antecedent cause(s) (b) <u>Chronic myocarditis also had</u>		<u>years.</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c) <u>arteriosclerosis with hypertention.</u>		<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Sept. 26/55  
 M.D. DEPUTY MEDICAL EXAMINER ☐  
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Sept. 27, 1955</u>	<u>Westcrest Cemetery</u>	<u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>Sept. 26, 1955</u>	<u>Marjorie C. Kelly</u>	<u>John G. Kaper</u>		
<u>Sept. 28-1955</u>				

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

SEP 30 1955

RECEIVED

1  
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08290

8263

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN (If rural give location)	
CITY OR TOWN <u>Cumberland,</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Cumberland,</u>		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Ridgeway Terrace</u>				STREET ADDRESS <u>15 Ridgeway Terrace</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY CATHERINE ROSE</u>				4. DATE OF DEATH <u>Sept. 30,</u> 19 <u>55</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Nov. 20, 1880</u>	
9. AGE last birthday <u>74</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John H. Diggs</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hammersmith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>4 No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Theodore M. Rose 15 Ridgeway Terrace</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic myocarditis &amp; myocardial degeneration</u>						<u>4 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterial hypertension</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerosis</u>						<u>3 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 3</u> , 19 <u>55</u> , to <u>Sept 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>55</u> , and that death occurred at <u>101</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. M. Swackis Jr</u>		M.D. <u>Cumberland, Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>9/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>S. S. Peter &amp; Paul's</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Maryland</u>			

98390

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

# CERTIFICATE OF DEATH

1923

Age and Sex

1. DECEASED WAS BORN (MONTH AND DAY)

2. DECEASED WAS BORN (CITY AND STATE)

3. DECEASED WAS BORN (CITY AND STATE)

4. DECEASED WAS BORN (CITY AND STATE)

5. DECEASED WAS BORN (CITY AND STATE)

6. DECEASED WAS BORN (CITY AND STATE)

7. DECEASED WAS BORN (CITY AND STATE)

8. DECEASED WAS BORN (CITY AND STATE)

9. DECEASED WAS BORN (CITY AND STATE)

10. DECEASED WAS BORN (CITY AND STATE)

11. DECEASED WAS BORN (CITY AND STATE)

12. DECEASED WAS BORN (CITY AND STATE)

13. DECEASED WAS BORN (CITY AND STATE)

14. DECEASED WAS BORN (CITY AND STATE)

15. DECEASED WAS BORN (CITY AND STATE)

16. DECEASED WAS BORN (CITY AND STATE)

17. DECEASED WAS BORN (CITY AND STATE)

18. DECEASED WAS BORN (CITY AND STATE)

19. DECEASED WAS BORN (CITY AND STATE)

20. DECEASED WAS BORN (CITY AND STATE)

21. DECEASED WAS BORN (CITY AND STATE)

22. DECEASED WAS BORN (CITY AND STATE)

23. DECEASED WAS BORN (CITY AND STATE)

24. DECEASED WAS BORN (CITY AND STATE)

25. DECEASED WAS BORN (CITY AND STATE)

10 years  
10 years  
10 years

Charles W. ...  
Baltimore ...  
Baltimore ...

BUREAU V. 8

OCT 4 1923

RECEIVED

1923 101 101

1923 101 101

11. DECEASED WAS BORN (CITY AND STATE)



8264

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>ALLEGANY</b>	CITY (If outside corporate limits, write RURAL OR TOWN) <b>CUMBERLAND</b>	STATE <b>MARYLAND</b>	COUNTY <b>ALLEGANY</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>CUMBERLAND</b>	
LENGTH OF STAY (in this place) <b>9 DAYS</b>		STREET ADDRESS (If rural give location) <b>517 WOODSIDE AVE.,</b>	

<b>3. NAME OF DECEASED</b> (Type or Print)		(First) <b>PATRICK</b>		(Middle) <b>E.</b>		(Last) <b>RYAN</b>		<b>4. DATE OF DEATH</b> (Month) <b>SEPT.</b> (Day) <b>6</b> (Year) <b>19 55</b>	
<b>5. SEX</b> <b>74</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>SINGLE</b>	<b>8. DATE OF BIRTH</b> <b>May 31, 1873</b>		<b>9. AGE last birthday</b> <b>77</b> yrs.		<b>IF UNDER 1 YEAR</b> (Months) <b>Days</b>		<b>IF UNDER 24 HRS.</b> (Hours) <b>Min.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Labor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND Cumberland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>EDWARD RYAN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MARGARET HOGAN</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-10-5206</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Julia W. Morris 517 Woodside Ave</b>					

<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1</b>		<b>IMMEDIATE CAUSE (A) Myocardial Failure</b>		<b>15 days?</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>		<b>(B) Myocardial Disease, Coronary Artery Disease and Auricular Fibrillation</b>		<b>??</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>		<b>(C) Gangrene, left foot</b>		<b>?</b>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>15 days?</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>	

**22. I hereby certify that I attended the deceased from August 28, 1955, to Sept. 6, 1955, that I last saw the deceased alive on Sept. 6, 1955, and that death occurred at 10:00AM from the causes and on the date stated above.**

**SIGNATURE** *[Signature]* **M. D.** **50 Pershing St. Cumberland, Md.** **DATE SIGNED** **9/7/55**

**23. BURIAL, CREMATION, REMOVAL (SPECIFY)** **DATE THEREOF** **NAME OF CEMETERY OR CREMATORY** **LOCATION (City, town, or county) (State)**

**Burial** **9-9-55** **St. Patrick Cem.** **Cumberland, Md.**

**24. REC'D BY REGISTRAR** **REGISTRAR'S SIGNATURE** **25. FUNERAL DIRECTOR'S SIGNATURE** **ADDRESS**

**Sept. 8, 1955** **Winters R. Frantz, M.D.** **James F. Scarpelli** **Cumberland, Md.**

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

08931

# CERTIFICATE OF DEATH

DEPT. 12

1. NAME OF DECEASED

MARYLAND

DATE OF DEATH

3 DAYS

PLACE OF DEATH

CONSUMPTION

217 WOODBINE AVE.

GENERAL HOSPITAL

SEX

PATRIOT

WHITE

SINGLE

KNOWS

MARYLAND

WILKINSON

IN MEDICAL CERTIFICATION

1. CAUSE OF DEATH

CONSUMPTION

1. CAUSE OF DEATH

CONSUMPTION

1. CAUSE OF DEATH

CONSUMPTION

1. CAUSE OF DEATH

CONSUMPTION

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CONSUMPTION

1. CAUSE OF DEATH

CONSUMPTION

1. CAUSE OF DEATH

BUREAU V. S.

1935

RECEIVED

THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, HAS RECEIVED THE FOLLOWING REPORT OF DEATH FROM THE LOCAL HEALTH OFFICER OF THE CITY OF BALTIMORE, MARYLAND, FOR THE MONTH OF DECEMBER, 1935.

8265

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE PENN.		COUNTY BEDFORD	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 1 DAY		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HYNDMAN		75 x 3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVENUE				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) MRS BLANCHE (First) (Middle) (Last) SATZER				4. DATE OF DEATH (Month) (Day) (Year) SEPT. 23, 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Nov. 6, 1892	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Clerk House	11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? XXXX U.S.A.	
13. FATHER'S NAME CHARLES MASON				14. MOTHER'S MAIDEN NAME ANNA KENDALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) Chronic Cordis Vascular Renal Disease				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1952 to Sep 23, 1955, that I last saw the deceased alive on Sep 23, 1955, and that death occurred at 8:00P M, from the causes and on the date stated above.							
SIGNATURE John A. Topper M.D.				ADDRESS (Street, city, town, state) Hyndman Pa		DATE SIGNED 9/25/55 (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 26, 1955		NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		LOCATION (City, town, or county) Hyndman, Pa.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Walter R. Brantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Harvey H. Zeigler, Hyndman, Pa.	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

INSTRUCTIONS

1. This form is to be filled out by the attending physician or other qualified person. It is to be filled out for all deaths, except those which are obviously accidental or suicidal, and for which a coroner's inquest is held. It is to be filled out for all deaths which are reported to the health department. It is to be filled out for all deaths which are reported to the health department. It is to be filled out for all deaths which are reported to the health department.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Form 100-104

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH

6. SEX

7. AGE

8. DATE OF BIRTH

9. PLACE OF BIRTH

10. SEX

11. AGE

12. DATE OF BIRTH

13. PLACE OF BIRTH

14. SEX

15. AGE

16. DATE OF BIRTH

17. PLACE OF BIRTH

18. SEX

19. AGE

20. DATE OF BIRTH

21. PLACE OF BIRTH

22. SEX

23. AGE

24. DATE OF BIRTH

25. PLACE OF BIRTH

26. SEX

27. AGE

28. DATE OF BIRTH

29. PLACE OF BIRTH

30. SEX

31. AGE

32. DATE OF BIRTH

33. PLACE OF BIRTH

34. SEX

35. AGE

36. DATE OF BIRTH

37. PLACE OF BIRTH

38. SEX

39. AGE

40. DATE OF BIRTH

41. PLACE OF BIRTH

42. SEX

43. AGE

44. DATE OF BIRTH

45. PLACE OF BIRTH

46. SEX

47. AGE

48. DATE OF BIRTH

49. PLACE OF BIRTH

50. SEX

51. AGE

52. DATE OF BIRTH

53. PLACE OF BIRTH

54. SEX

55. AGE

56. DATE OF BIRTH

57. PLACE OF BIRTH

58. SEX

59. AGE

60. DATE OF BIRTH

61. PLACE OF BIRTH

62. SEX

63. AGE

64. DATE OF BIRTH

65. PLACE OF BIRTH

66. SEX

67. AGE

68. DATE OF BIRTH

69. PLACE OF BIRTH

BUREAU V. 1

SEP 27 1955

RECEIVED

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8266

## CERTIFICATE OF DEATH

08293

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>CUMBERLAND</b>		<b>69 DAYS</b>		TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>60 MEMORIAL HOSPITAL</b>				<b>535 N. CENTRE STREET</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<b>ELIZABETH</b> (First) (Middle) (Last)				<b>SEPT. 12</b> (Month) (Day) (Year)		<b>55</b>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>FEMALE</b>	<b>WHITE</b>	<b>WIDOW</b>	<b>JAN. 4 1874</b>	<b>81</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>House Wife</b>		<b>Own House</b>		<b>WEST VIRGINIA</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>SAMUEL FULLER</b>				<b>HATTIE SPOERLING</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>		<b>None</b>		<b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>493X IMMEDIATE CAUSE (A)</b>						<b>Pneumonia, Infl.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>						<b>Septicemia</b>	
<b>STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7/5, 1955, to 9/12, 1955, that I last saw the deceased alive on 9/11, 1955, and that death occurred at 3:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>Dr. H. L. Key Jr.</b>				<b>M.D. 456 N. Centre St. Cumberland</b>		<b>9/12/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>Sept 14/55</b>		<b>Spurling Cemetery</b>		<b>Junction, W. Va.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>Sept. 12, 1955</b>		<b>Walter R. Frantz, M.D.</b>		<b>Meryl Combs,</b>		<b>Romney, W. Va.</b>	







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## I. PLACE OF DEATH:

COUNTY Alleghany MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland LENGTH OF STAY (in this place) 9 hrs.HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE M d. COUNTY AlleghanyCITY (If outside corporate limits write RURAL) and give nearest town) Cumberland, ruralSTREET ADDRESS (If rural, give location) R.F.D. #1 LaVale

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CliftonVermontShriver

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

Sept. 619 55

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

201X  
Immediate cause(a) Hodgkins disease (abdominal)  
DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Pulmonary infarct  
DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Arthritis

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at Not while work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

H. V. Deming M.D.

M. D. DEPUTY ASSISTANT MEDICAL EXAM.

Sept 7-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Sept. 9, 1955 Dr. R. Frank M.D.John J. Rager, Cumberland, Maryland

BUREAU V. S.

SEP 13 1955

RECEIVED

1

INSTRUCTIONS

I

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08295

8297

## CERTIFICATE OF DEATH

Reg. Dist. No. 14

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Ellerslie</u>		<u>15 years</u>		TOWN <u>Ellerslie</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		/	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Moses Edward Shroyer</u>				<u>Sept. 27, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Feb. 22, 1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Motorman</u>		<u>Street car</u>		<u>Hyndman, Pa. RD#1</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Moses E. Shroyer</u>				<u>Jane Frolick Mary Logsdon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>George W. Shroyer, Ellerslie, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
18. MEDICAL CERTIFICATION							
<u>422.2</u> IMMEDIATE CAUSE (A) <u>Chronic Myocardosis</u>						<u>10 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>45</u> , to <u>Sept. 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 27</u> , 19 <u>55</u> , and that death occurred at <u>Hyndman</u> , M., from the causes and on the date stated above.							
SIGNATURE <u>John L. Topper MD</u>				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u>		DATE SIGNED <u>Sept 28-1955</u>	
M.D. <u>Hyndman Pa</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 30, 1955</u>		<u>Cooks Mills Cemetery</u>		<u>Hyndman, Pa. RD#1</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept 28, 55</u>		<u>J. L. Wolfe</u>		<u>Harvey H. Zeigler</u>		<u>Hyndman, Pa.</u>	

10510

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

# CERTIFICATE OF DEATH

10510

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. MARITAL STATUS

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEAREST RELATIVE

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF CORONER

32. SIGNATURE OF JURY

33. SIGNATURE OF JUDGE

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF CORONER

36. SIGNATURE OF JURY

37. SIGNATURE OF JUDGE

38. SIGNATURE OF SHERIFF

39. SIGNATURE OF CORONER

40. SIGNATURE OF JURY

41. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CORONER

44. SIGNATURE OF JURY

45. SIGNATURE OF JUDGE

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF CORONER

48. SIGNATURE OF JURY

49. SIGNATURE OF JUDGE

50. SIGNATURE OF SHERIFF

51. SIGNATURE OF CORONER

52. SIGNATURE OF JURY

53. SIGNATURE OF JUDGE

54. SIGNATURE OF SHERIFF

55. SIGNATURE OF CORONER

56. SIGNATURE OF JURY

57. SIGNATURE OF JUDGE

58. SIGNATURE OF SHERIFF

59. SIGNATURE OF CORONER

60. SIGNATURE OF JURY

61. SIGNATURE OF JUDGE

62. SIGNATURE OF SHERIFF

63. SIGNATURE OF CORONER

64. SIGNATURE OF JURY

65. SIGNATURE OF JUDGE

BUREAU V. 8

OCT 6 1955

RECEIVED

10510

1

RECEIVED  
OCT 6 1955  
BUREAU V. 8

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08296

8268

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Allegany</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Allegany</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b>	LENGTH OF STAY (in this place) <b>7 mo.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Sylvan Retreat</b>		STREET ADDRESS (If rural give location) <b>408 Goethe Street</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>Charles Perry Smith</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 16 1955</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>M</b>	8. DATE OF BIRTH <b>March 23, 1871</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P. Railroad</b>	9. AGE last birthday <b>84</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <b>Mt. Savage, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME <b>Anne Hoebrook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS <b>Mrs. C. P. Smith, 408 Goethe St.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)		<b>Chronic Myocarditis</b> <b>Central Arteriosclerosis</b> <b>Chronic Hepatitis</b> <b>Severe psychosis.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <b>1949.</b>	
19a. DATE OF OPERATION <b>8</b>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb. 15 1955</b> , to <b>Sept. 16 1955</b> , that I last saw the deceased alive on <b>Sept. 15, 1955</b> , and that death occurred at <b>7:45A</b> M, from the causes and on the date stated above.			
SIGNATURE <b>James B. McLean M.D.</b>		ADDRESS (Street, city, town, state) <b>49 Greene St.</b>	
DATE SIGNED <b>9-16-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept 18, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		LOCATION (City, town, or county) (State) <b>Eckhart, Maryland</b>	
24. REC'D BY REGISTRAR <b>Sept. 17, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Frantz, M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		ADDRESS <b>Cumberland, Maryland</b>	

RECEIVED

SEP 20 1955

BUREAU V. 2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH-BALTIMORE, MD.  
1955

**CERTIFICATE OF DEATH**

1. NAME OF DECEASED: Anna Beckwith

2. SEX: Female

3. AGE: 70

4. DATE OF BIRTH: March 23, 1871

5. PLACE OF BIRTH: St. Louis, Mo.

6. OCCUPATION: None

7. MARITAL STATUS: Widow

8. CAUSE OF DEATH: Senile Dementia

9. PLACE OF DEATH: Home

10. DATE OF DEATH: September 15, 1955

11. SIGNATURE OF PHYSICIAN: [Signature]

12. SIGNATURE OF REGISTRAR: [Signature]



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08297

8298

## CERTIFICATE OF DEATH

Reg. Dist. No. *X*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <u>Barrelville</u>				TOWN <u>Barrelville</u>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At Home, Barrelville, Md.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MELVIN</u> (Middle) <u>CLEBERN</u> (Last) <u>SUTHERLEN</u>				(Month) <u>September</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Feb. 26, 1889</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Painter</u>				<u>Hugo, Oklahoma</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN SUTHERLEN</u>				<u>FLORENCE HANNA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<u>452-14-2152</u>		<u>Mrs. Frank Johns, Barrelville, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422.2 Myocarditis - Dilated Heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>October 1954</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Edema</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchial asthma</u>				<u>5 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January</u> , 19 <u>50</u> , to <u>9-6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-6</u> , 19 <u>55</u> , and that death occurred at <u>9:04</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William E. Mosley</u>				ADDRESS (Street, city, town, state) <u>Mt Savage Md.</u>			
DATE <u>Sept. 7, 1955</u>				DATE SIGNED <u>9-7-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Sept. 8, 1955</u>		<u>Cook's Cemetery</u>		<u>Nr. Wellersburg, Pennsylv</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 7, 1955</u>		<u>Veronica M. Lermitt</u>		<u>John J. Hafer</u>		<u>Cumberland, Maryland</u>	



1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08298

8269

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>2 yrs</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>345 Frederick Street</u>				STREET ADDRESS (If rural give location) <u>345 Frederick Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MOSES TAYLOR</u>				<u>Sept. 7 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>March 10, 1882</u>	<u>73</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Net. Janitor</u>		<u>Kelly-Springfield</u>		<u>Cumberland, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>JANE WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>220-10-2610</u>		<u>Mrs. Katie Taylor, Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 days</u>	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Coronary Disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis Heart Disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 6</u> , 19 <u>55</u> , to <u>Sept 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>55</u> , and that death occurred at <u>Sept 7</u> , 19 <u>55</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>B. M. Schindler</u>				DATE SIGNED <u>9/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Sept. 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Sumner Cemetery</u>	
						LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Sept. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	



1 Without corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8270

CERTIFICATE OF DEATH

08299

Reg. Dist. No. 4

M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		2 DAYS		TOWN FROSTBURG		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
MEMORIAL HOSPITAL				23 BROADWAY (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ANNIE THOMAS				SEPTEMBER 4 19 55			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
FEMALE		WHITE		SINGLE		AUGUST 10 - 1976	
						79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housework				Home		MARYLAND	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
JOHN THOMAS				U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
None				None		MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A) Cancer stomach, advanced						Approx 2 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) with post operative shock						18 hours	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Sep 3, 1955		Advanced Ca Stomach with diffuse metastases					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sep 2, 1955, to Sep 4, 1955, that I last saw the deceased alive on Sep 4, 1955, and that death occurred at 6:10A.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
Wm Fawcett		Cumberland Md				Sep 4 '55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-6-55		Fby Memorial Park		Frostburg Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sep 5, 1955		Wm R. Fawcett, M.D.		J. P. Ours		Frostburg Md	



# CERTIFICATE OF DEATH

1935

File No.

1. NAME OF DECEASED

JOHN J. HANLEY

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF JUDGE

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF REGISTRAR

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF DEPUTY SHERIFF

25. SIGNATURE OF CONSTABLE

26. SIGNATURE OF JURY

27. SIGNATURE OF JUDGE

28. SIGNATURE OF CLERK

29. SIGNATURE OF REGISTRAR

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF DEPUTY SHERIFF

32. SIGNATURE OF CONSTABLE

33. SIGNATURE OF JURY

34. SIGNATURE OF JUDGE

35. SIGNATURE OF CLERK

36. SIGNATURE OF REGISTRAR

37. SIGNATURE OF SHERIFF

38. SIGNATURE OF DEPUTY SHERIFF

39. SIGNATURE OF CONSTABLE

40. SIGNATURE OF JURY

BUREAU V. S.

SEP 8 1935

RECEIVED

RECEIVED  
SEP 10 1935  
BALTIMORE  
M.D.



1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08300

8271

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>4 DAYS</u>		TOWN <u>FLINSTONE, rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>MEMORIAL HOSPITAL</u>				<u>RT. #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MRS. EMMA</u> (Middle) <u>A.</u> (Last) <u>TWIGG</u>				(Month) <u>SEPT.</u> (Day) <u>1</u> (Year) <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>NOV. 27, 1874</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housekeeper at Home</u>					<u>MARYLAND</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ROSS TWIGG</u>				<u>LUCY SRRINGSTEEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>none</u>		<u>MEMORIAL HOSPITAL, CUMBERLAND, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 Hours</u>	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arterio Sclerotic Cerebro Vascular Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 1955</u> to <u>Sept 1955</u> , that I last saw the deceased alive on <u>9/1/55</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William W. Wright</u>				ADDRESS (Street, city, town, state) <u>M.D. 133 Virginia Ave Cumberland, Md</u>		DATE SIGNED <u>9/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>9/4/55</u>		<u>Oldtown Cemetery</u>		<u>Oldtown Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 4, 1955</u>		<u>Winters R. Frantz, M.D.</u>		<u>H. Lee Silcox</u>		<u>Cumberland, Md.</u>	

10330

# CERTIFICATE OF DEATH

8271

Day, Date, Year

1. Name of deceased

2. Sex

3. Age

4. Race

5. Birth date

6. Place of birth

7. Date of death

8. Cause of death

9. Place of death

10. Signature of physician

11. Date of death

12. Time of death

13. Signature of registrar

14. Signature of medical examiner

15. Signature of coroner

16. Signature of funeral director

17. Signature of health officer

18. Signature of registrar

19. Signature of medical examiner

20. Signature of coroner

21. Signature of funeral director

22. Signature of health officer

*Handwritten notes:*  
Cerebral hemorrhage  
Hypertension  
Hypertension  
Hypertension

**BUREAU V. S.**

668 B. 1925

*Handwritten signatures and stamps:*  
[Illegible signatures and stamps]

8272

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN CUMBERLAND</b>		LENGTH OF STAY (in this place) <b>29 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>02 TOWN CUMBERLAND, rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60 MEMORIAL HOSPITAL</b>		STREET ADDRESS <b>RT. #1 CUMBERLAND</b>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>CARL ELTON VAN AUSDALE</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>SEPTEMBER 1, 19 55</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>SEPT. 16, 1898</b>	<b>9. AGE last birthday</b> <b>56</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>WHITE HAINES OPTICAL CO.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>OHIO</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>SCOTT VAN AUSDALE</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>SARAH BAXTER</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Yes H. H. I</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MEMORIAL HOSPITAL -CUMBERLAND, MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>151X IMMEDIATE CAUSE (A)</b> <b>Colinomatosis</b>						<b>2 years</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Colinoma Stomach</b>						<b>2 years</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>27 Aug. 55</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Colinoma stom. with metastases</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 28 Aug. 55, to 1 Sept. 55, that I last saw the deceased alive on 1 Sept. 55, and that death occurred at 10:35 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>W. A. Van Osma</b>				<b>ADDRESS (Street, city, town, state)</b> <b>Cumberland, Md.</b>			
<b>DATE SIGNED</b> <b>3 Sept. 55</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Sept. 5, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Marys Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Cumberland, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Sept. 4, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Walter R. Frank, M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles L. George, Cumberland, Md.</b>			

INSTRUCTIONS

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

7

BUREAU V. 8.

CCF 9-23

Outside of  
City Limits

8273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08302

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN <u>Rural) Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#3 Bowmans Addition</u>		<u>17 years</u>		STREET ADDRESS (If rural, give location)		<u>R.F.D.#3 Bowmans Addition.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>George Washington Walker</u>				<u>Sept. 27 19 55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH: <u>Sept. 29-1880</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>W.P.A.</u>		11. BIRTHPLACE (State or foreign country): <u>Lost River, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jake Walker</u>				14. MOTHER'S MAIDEN NAME: <u>Jamima Conner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Memorial Hospital records.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>420.1</u>		
Immediate cause (a) <u>Coronary occlusion</u>		<u>Gradual</u>
DUE TO		
Antecedent cause(s) (b) <u>Coronary sclerosis also had</u>		<u>?</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO		<u>over 1</u>
stating underlying cause last (c) <u>Arteriosclerosis with hypertension</u>		<u>year</u>
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <u>Sept. 29, 1955</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Sept. 27/55  
H. V. Deming M.D. M. D. DEPUTY MEDICAL EXAMINER ☐  
H. V. Deming M.D. M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Sept. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Stoney Creek Cemetery, Romney, West Virginia</u>		LOCATION (City, town, or county), (State): <u>West Virginia</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 28, 1955</u>		REGISTRAR'S SIGNATURE: <u>Walter R. Tamm, M.D.</u>		24. FUNERAL DIRECTOR: <u>Brush Funeral Home, Romney, W. Va.</u>		ADDRESS: <u>Brush Funeral Home, Romney, W. Va.</u>	

Thomson

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 29 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08303

8290

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		STATE <u>Md.</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>22 Frostburg</u>		LENGTH OF STAY (in this place) <u>50 yrs.</u>		TOWN <u>22 Frostburg</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>47 Linden St.</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>47 Linden St.</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elizabeth Ward</u>				<b>4. DATE OF DEATH</b> (Month) <u>8</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>10-9-1872</u>	
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Jennings Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jonas Folk</u>				14. MOTHER'S MAIDEN NAME <u>Suzanna Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS <u>Mr. Ray Ward, Son, 47 Linden St.</u>							
<b>18. MEDICAL CERTIFICATION</b>				<b>19. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
422.1 IMMEDIATE CAUSE (A) <u>Acute Cardiac Failure</u>				<u>10 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerotic Ch V disease</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>				<u>10 yrs.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>				<u>5 yrs.</u>			
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-1</u> , 19 <u>50</u> , to <u>8-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-29</u> , 19 <u>55</u> , and that death occurred at <u>10 P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>H.C. Dickel</u>				DATE SIGNED <u>8/31/55</u>			
ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-1-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial</u>		LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR <u>9-2-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pearl H. Mattingly</u>		ADDRESS <u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

1930

THE COUNTY OF SUFFOLK, ss.

STATE OF MASSACHUSETTS, ss.

I, the undersigned, Registrar of the County of Suffolk, do hereby certify that

the within and foregoing is a true and correct copy of the original

record of the death of the person named herein.

Witness my hand and the seal of the County of Suffolk, this 10th day of

January, 1930.

Attest:

JOHN B. BROWN, Registrar of the County of Suffolk.

JOHN B. BROWN, Registrar of the County of Suffolk.

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BUREAU V. S.

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RECEIVED

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1930

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland  
TOWN Cumberland LENGTH OF STAY (in this place) 46 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS 337 Davidson St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) Cumberland  
TOWN Cumberland

STREET ADDRESS (If rural, give location) 337 Davidson St.

3. NAME OF DECEASED: (First) (Middle) (Last)  
(Type or Print) Adelaide Catherine Ways

4. DATE OF DEATH (Month) (Day) (Year)  
Sept. 6 1955

5. SEX: female 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow 8. DATE OF BIRTH: June 20-1873 9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Sept. 6 1955

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife 10b. KIND OF BUSINESS OR INDUSTRY: Own Home 11. BIRTHPLACE (State or foreign country): Cumberland, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

Jacob D. George

## 14. MOTHER'S MAIDEN NAME:

Margaret C. Wineow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

## 17. INFORMANT &amp; ADDRESS:

(daughter) Georgie Ways, Cumberland, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
Immediate cause (a) Coronary occlusion

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Coronary sclerosis.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH  
sudden

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.  
SIGNATURE

H. V. Deming, M.D.

M. D.

CHIEF MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED Sept. 6-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Sept. 9, 1955

NAME OF CEMETERY OR CREMATORY Greenmount Cemetery

LOCATION (City, town, or county) Cumberland, Maryland

(State)

DATE REC'D BY LOCAL REG. Sept. 7, 1955

REGISTRAR'S SIGNATURE Walter R. Prantz, M.D.

24. FUNERAL DIRECTOR Charles L. George, "

ADDRESS "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 8 1955  
BUREAU V. S.

8275

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 70M

1. PLACE OF DEATH COUNTY <b>ALLEGANY</b> CITY OR TOWN <b>CUMBERLAND</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>CUMBERLAND</b> STREET ADDRESS (If rural give location) <b>605 COLUMBIA AVENUE</b>			
3. NAME OF DECEASED (Type or Print) <b>EDNA F. WILT</b>				4. DATE OF DEATH <b>SEPT. 13 1955</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>SEPT. 5, 1904</b>	9. AGE last birthday <b>51</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>MD. Twenty First Bridge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DAYTON, EDWARD</b>				14. MOTHER'S MAIDEN NAME <b>DAWSON, LUCY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 441X IMMEDIATE CAUSE (A) <b>Uremia</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertension Maligant</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Cardiac Hypertrophy</b>						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>8</b>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21e. INJURY OCCURRED While el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>25 Aug 1955</b> , to <b>12 Sept 1955</b> , that I last saw the deceased alive on <b>12 Sept 1955</b> , and that death occurred at <b>1:15 A.M.</b> on the causes and on the date stated above. SIGNATURE <b>Walter B. Whitworth M.D.</b> ADDRESS (Street, city, town, state) <b>123 Bedford St. Carlisle Pa 15801</b> DATE SIGNED <b>12 Sept 1955</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept 16, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Philost Cemete</b>		LOCATION (City, town, or county) (State) <b>Westernport, Maryland</b>	
24. REC'D BY REGISTRAR <b>Sept. 15, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Frank, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>			

25-52

BUREAU V. S.

SEP 16 1955

RECEIVED



## INSTRUCTIONS

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08306

8276

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 TOWN Cumberland</u>		LENGTH OF STAY (In this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Lonaconing</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>Dudley Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Maude</u> (First) <u>Yates</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 10</u> <u>19</u> <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 19th. 1884</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Barton, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mowbray</u>				14. MOTHER'S MAIDEN NAME <u>Jane Ann - Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Elizabeth Yates, Lonaconing, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION (Daughter)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>2d</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>						<u>3-4 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>July 10, 1955</u> , <b>to</b> <u>10 Sept. 55</u> , <b>that I last saw the deceased alive on</b> <u>10 Sept. 55</u> , <b>and that death occurred at</b> <u>2:00 P.M.</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>George Eichhorn</u> <b>M.D.</b> <u>Lonaconing Md</u> <b>DATE SIGNED</b> <u>9-12-55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery, Moscow, MD.</u>		LOCATION (City, town, or county) (State) <u>Lonaconing, MD.</u>	
24. REC'D BY REGISTRAR <u>Sept. 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>		ADDRESS	

SHORTLY AFTER

THE FOLLOWING INFORMATION WAS OBTAINED FROM THE RECORDS OF THE BALTIMORE HEALTH DEPARTMENT ON SEPTEMBER 15, 1955:

# CERTIFICATE OF DEATH

8278

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

8278

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF DEATH

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PLACE OF BIRTH

BUREAU V.

SEP 15 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

08307

Reg. Dist. No. 4

8277

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND, MD.</b>		LENGTH OF STAY (in this place) <b>32 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>336 AVIRETT AVENUE</b>					
3. NAME OF DECEASED (Type or Print) <b>SUSAN Lambie YEAGER</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT. 26 1955</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JAN. 7, 1864</b>	9. AGE last birthday <b>91</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>SCOTLAND Edinboro</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Osborne</b>				14. MOTHER'S MAIDEN NAME <b>Jean ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <b>Cerebral Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>From 8-27-55</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized Arterio Sclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8-23-55</b> , 19 <b>55</b> , to <b>8-26-55</b> , that I last saw the deceased alive on <b>8-25-55</b> , 19 <b>55</b> , and that death occurred at <b>5:10 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>W. F. Williams, M.D.</b>				ADDRESS (Street, city, town, state) <b>Cumberland Md</b>		DATE SIGNED <b>9-26-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>9/28/55</b>		NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. REC'D BY REGISTRAR <b>Sept. 28, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Hantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU A. S.

SEP 29 1955

1979